

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

<p>James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen, et. al,</p> <p style="text-align: right;">Plaintiffs,</p> <p>vs.</p> <p>Minnesota Department of Human Services, an agency of the State of Minnesota, et. al.,</p> <p style="text-align: right;">Defendants.</p>	<p>Court File No.: 09-CV-1775 DWF/FLN</p> <p style="text-align: center;">DECLARATION OF SHAMUS P. O’MEARA</p>
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STATE OF MINNESOTA)
)
COUNTY OF RAMSEY)

I, Shamus P. O’Meara, state and declare as follows:

1. I am counsel for Plaintiffs in this matter.
2. Attached as **Exhibit A** is a true and correct copy of Mid-Minnesota Legal Aid Minnesota Disability Law Center’s letter dated February 24, 2014, regarding Abuse and Neglect Investigation of the Anoka Metro Regional Treatment Center.
3. Attached as **Exhibit B** is a true and correct copy of Mid-Minnesota Legal Aid Minnesota Disability Law Center’s letter dated September 27, 2016, regarding Findings and Recommendations of Mid-Minnesota Legal Aid’s Minnesota Disability Law Center Restraint and Seclusion Investigation of the Anoka Regional Treatment Center.
4. Attached as **Exhibit C** is a true and correct copy of Mid-Minnesota Legal Aid Minnesota Disability Law Center’s July 29, 2015, Investigation Report: Restraint and Seclusion at the Minnesota Security Hospital.

5. Attached as **Exhibit D** is a true and correct copy of Minnesota Department of Human Services' letter dated October 30, 2013, to Court Monitor David Ferleger responding to "Request No. 2013-10: AMRTC and MSH Records on Restraint and Seclusion Use."

6. DHS communicated and provided information to the Court Monitor, Consultants and Class Counsel, including, for example, DHS emails dated October 31, 2013 (providing information responding to monitor's Request No. 2013-10: AMRTC and MSH Records); November 27, 2013 and December 02, 2013 (providing Anoka incident reports monitor requested); January 3, 2014 (providing monitor information in response to Request No. 2013-14: Anoka and MSH Incident Reports); and January 16, 2014 (5 emails providing monitor with information responding to Request No. 2013-15: Anoka and MSH Restraint and Seclusion Reports).

I declare, under penalty of perjury, that everything I have stated in this Declaration is true and correct.

Dated: January 17, 2020

/s/ Shamus P. O'Meara

Shamus P. O'Meara

sPO Declaration.doc



**MID-MINNESOTA LEGAL AID
MINNESOTA DISABILITY LAW CENTER**
Duluth Fertile Grand Rapids Mankato Minneapolis
Steven C. Schmidt ▪ (612) 746-3620 ▪ sschmidt@mylegalaid.org

February 24, 2014

VIA USPS CERTIFIED MAIL RETURN RECEIPT
Receipt # 7012 3460 0003 6391 4412

Steven Allen, Executive Director
Mental Health and Substance Abuse Treatment Services
Anoka Metro Regional Treatment Center
3301 Seventh Avenue North
Anoka, MN 55303-4516

RE: Abuse and Neglect Investigation of the Anoka Metro Regional Treatment Center

Dear Mr. Allen:

My name is Steven Schmidt, and I am a staff attorney with the Minnesota Disability Law Center (MDLC). The MDLC is a statewide division of Mid-Minnesota Legal Aid (MMLA), the federally mandated Protection and Advocacy (P & A) System for the state of Minnesota. The P&A system is a nationwide network of disability rights agencies created by Congress to protect the rights of individuals with disabilities.

Our office has received and reviewed the October 17, 2013 report from Federal Court Monitor David Ferleger entitled *Restraint Chair and Seclusion Use at AMRTC and MSH: Phase 1 Review*. This report details the extensive use of restraint and seclusion at the Anoka Metro Regional Treatment Center (AMRTC). This report provides probable cause to suspect that abuse and neglect has occurred at the AMRTC. As a result, our office will be conducting an abuse and neglect investigation of the AMRTC pursuant to our authority and responsibility under federal law.

Legal Background

Congress has enacted statutes which grant all P & A systems, including the MDLC, the authority to investigate incidents of abuse and neglect that are reported to the system. See 42 U.S.C. § 10805(a)(1)(A); 42 U.S.C. § 15043(a)(2)(B)(i). Any communication, whether formal or

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A United Way Agency

Steven Allen, Executive Director

February 24, 2014

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informal, written or oral, received by the P & A system from any source alleging abuse or neglect may be considered a report of abuse or neglect. *See* 42 C.F.R. § 51.2; 45 C.F.R. § 1386.19. Federal law also provides that P & A systems may conduct investigations when there is probable cause to believe that incidents of abuse and neglect have occurred. *See* 42 U.S.C. § 10805(a)(1)(A); 42 U.S.C. § 15043(a)(2)(B)(i). The law defines “probable cause” as a reasonable ground for belief that an individual has been, or may be, subject to abuse or neglect. *See* 42 C.F.R. § 51.2; 45 C.F.R. § 1386.19. As the state’s P & A system, the MDLC is the arbiter of whether there is probable cause to conduct an abuse and neglect investigation. *See Arizona Center for Disability Law v. Allen*, 197 F.R.D. 689 (D. Ariz. 2000).

The definition of “abuse” includes the use of excessive force while placing individuals in bodily restraints, the use of bodily or chemical restraints which is not in compliance with federal and state laws and regulations, and any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue. *See* 42 C.F.R. § 51.2; 45 C.F.R. § 1386.19. The definition of neglect includes a failure to provide appropriate individual treatment plans and a failure to provide a safe environment. *See* 42 C.F.R. § 51.2; 45 C.F.R. § 1386.19.

Restraint and Seclusion is Abuse and Neglect

The harmful consequences of restraint and seclusion are well documented. Restraint and seclusion practices “are widely acknowledged to be violent, stressful, and humiliating incidents, both for patients and for the staff members imposing them.” Stephen Haimowitz, et al., *Restraint and Seclusion: A Risk Management Guide*, CAP, ICADC (Sept 2006). The use of restraints puts patients at risk for physical injury and death. *See* W.K., Mohr et al., *Adverse Effects Associated with Physical Restraint*. *Can J Psychiatry*. 2003; 48:330–33. Asphyxia, aspiration and cardiac events are all possible results of the use of restraint. *Id.*

The Minnesota Department of Human Services (DHS) has recognized that the use of restraint and seclusion is an abusive practice. DHS has stated that it will “prohibit procedures that cause pain, whether physical, emotion or psychological, and establish a plan to prohibit use of seclusion and restraints for programs and services licensed or certified by the department.” *See Rule 40 Advisory Committee Recommendation on Best Practices and Modernization of Rule 40* (July 2, 2013). DHS has committed itself to not only “follow legal and regulatory requirements limiting the use of seclusion and restraint,” but to create a “broader culture that honors the trust placed in [DHS] both as a provider and as a department responsible for the administration and oversight of many of the services that support citizens.” *See DHS Respect and Dignity Practices Statement* (June 20, 2013).

Reports of Abuse and Neglect – October 17, 2013 Court Monitor’s Report

On October 17, 2013, Federal Court Monitor David Ferleger issued a report entitled *Restraint Chair and Seclusion Use at AMRTC and MSH: Phase 1 Review* (“Ferleger Report”). Mr. Ferleger wrote this report as part of his ongoing role as Court Monitor for the *Jensen v. Minnesota Department of Human Services* settlement agreement.

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In his report, Mr. Ferleger outlines the use of restraint and seclusion at the Anoka Metro Regional Treatment Center (AMRTC). Mr. Ferleger reviewed data obtained from DHS on the use of restraints and seclusion at AMRTC. Based on his review, Mr. Ferleger calculated that the average use of the restraint chair at AMRTC was 566 minutes per month from January 2012 to August 2013. *See* Ferleger Report, chart following p. 8. Mr. Ferleger calculated that the average use of seclusion at AMRTC during that time period was 148 minutes per month. *Id.* Mr. Ferleger also examined the use of restraint and seclusion on individual patients. Mr. Ferleger noted that one patient at AMRTC was held in a restraint chair for 85 hours over 35 times during February of 2012. *Id.* at p. 8.

Mr. Ferleger determined that “there is significant use of the restraint chair and of seclusion” at AMRTC. *Id.* at p. 8. Mr. Ferleger concluded that despite the terms of the *Jensen* settlement and DHS’ commitment to eliminate restraint and seclusion, AMRTC continues to use these aversive practices. *Id.* at p. 10.

The MDLC has concluded that the October 17, 2013 Court Monitor’s Report is a report of abuse and neglect received by the P & A system. Moreover, the information provided in Mr. Ferleger’s report provides probable cause that incidents of abuse and neglect have occurred at AMRTC. As a result, our office will be conducting an abuse and neglect investigation at the AMRTC pursuant to our authority and responsibility under federal law.

Our Investigation

Federal law sets forth various requirements that must be followed during an abuse and neglect investigation. Our office must receive access to facilities, clients and records in order to make a determination about whether an allegation of abuse or neglect is taking place or has taken place. 42 C.F.R. § 51.2; 45 C.F.R. § 1386.19 The data we have access to includes intake, assessment, case notes, nursing notes, evaluations, supportive and other services, financial records, steps taken to investigate incidents, discharge planning records and reports prepared by an agency charged with investigating abuse, neglect, or injury. 42 C.F.R. 51.42(c); 45 C.F.R. §1386.22(h). This right of access includes access to confidential data to which a data subject or legal representative does not have access, including incident reports and peer reviews. *See Indiana Prot. & Advocacy Servs. v. Indiana Family & Soc. Servs. Admin.*, 603 F.3d 365, 382 – 83 (7th Cir. 2010).

Moreover, our office must have reasonable unaccompanied access to residents at all times necessary to conduct a full investigation of an incident of abuse or neglect. *See* 42 C.F.R. § 51.42(d); 45 C.F.R. § 1386.22(h). Unaccompanied access includes the opportunity to meet and communicate privately with the residents of a facility, both formally and informally, by telephone, mail or in person. *See* 42 C.F.R. § 51.42(d); 45 C.F.R. § 1386.22(h). A resident includes minors and adults who have legal guardians (*see* 42 C.F.R. § 51.42(c)).

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We request that you or another representative from DHS contact me in the next two weeks so we may make arrangement to begin the abuse and neglect investigation. Thank you for your attention to this matter.

Sincerely,



Steven C. Schmidt

Staff Attorney

SCS:nb

cc: Anne Barry, Deputy Commissioner



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September 27, 2016

Derrick Jones
Interim Director
Anoka Metro Regional Treatment Center
3301 Seventh Avenue
Anoka, MN 55303

RE: Restraint and Seclusion Investigation of the Anoka Metro Regional Treatment Center: Findings and Recommendations of Mid-Minnesota Legal Aid's Minnesota Disability Law Center

Dear Mr. Jones:

This year, Mid-Minnesota Legal Aid's Minnesota Disability Law Center (MDLC) conducted an investigation into the use of restraint and seclusion at the Anoka Metro Regional Treatment Center (AMRTC). This letter summarizes MDLC's findings, and sets forth recommendations to reduce the use of restraint and seclusion at AMRTC.

Background

In the last several years, state licensing authorities, the Minnesota Legislative Auditor, and numerous media reports have raised alarms about the use of restraint and seclusion at facilities operated by the Minnesota Department of Human Services (DHS), including the Anoka Metro Regional Treatment Center (AMRTC). In 2009, a federal lawsuit was filed on behalf of individuals with developmental disabilities who were unjustifiably restrained and secluded in Minnesota Extended Treatment Options (METO), in violation of their civil rights.¹ The case settled, and a Court Monitor was appointed to oversee implementation of the settlement, including reform of the state's use of restraint and seclusion. On October 17, 2014, Court Monitor David Ferleger issued a report entitled *Restraint Chair and Seclusion Use at MSH and*

¹ See *Jensen v. Minn. Dep't of Human Servs.*, No. 09-cv-1775-DWF-FLN, [2011 WL 6178845](#), at *1 (D. Minn. Dec. 5, 2011).

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*AMRTC: Phase 1 Review.*² The report found that, despite the terms of the *Jensen* settlement and a DHS commitment to eliminate restraint and seclusion, AMRTC continues to use these aversive practices.³

The Court Monitor's Report came to the attention of Mid-Minnesota Legal Aid's Minnesota Disability Law Center. Mid-Minnesota Legal Aid is designated by gubernatorial executive order as the federal Protection and Advocacy (P & A) System for the state of Minnesota and performs this function through the MDLC. Federal statutes grant P & A systems the authority to investigate incidents of abuse and neglect.⁴ Unnecessary restraint and seclusion meet the definition of abuse as defined by federal law.⁵ MDLC determined that the Court Monitor's Report established probable cause that incidents of abuse and neglect have occurred at AMRTC. MDLC then initiated this investigation pursuant to our authority and responsibility under federal law.

To carry out the investigation, MDLC took the following steps:

- MDLC initiated its investigation of both MSH and AMRTC in February of 2014. After receiving a response to its initial data request, MDLC determined that it would first focus its investigational resources on the use of restraint and seclusion at the Minnesota Security Hospital. MDLC proceeded with an investigation of MSH, and issued a final report on July 29, 2015.
- After concluding its investigation of MSH, MDLC reinitiated its investigation of AMRTC. On September 16, 2015, MDLC requested policies and data from DHS regarding the use of restraint and seclusion, including the names of individuals who had been restrained and/or secluded from January 1, 2014 to September 16, 2015.

² Restraint Chair and Seclusion Use at AMRTC and MSH: Phase 1 Review, *Jensen*, [2011 WL 6178845](#) (2013) (No. 09-cv-01775-DWF-FLN), [ECF No. 236](#).

³ *Id.* at 10.

⁴ Federal law provides that P & A systems may conduct investigations when there is probable cause to believe that incidents of abuse and neglect have occurred. See 42 U.S.C. §§ 10805(a)(1)(A), 15043(a)(2)(B) (2012). The law defines "probable cause" as "reasonable grounds for belief that an individual has been, or may be, subject to abuse or neglect." [42 C.F.R. § 51.2](#) (2015); see also [45 C.F.R. § 1386.19](#). As the state's P & A system, the MDLC is the arbiter of whether there is probable cause to conduct an abuse and neglect investigation. See, e.g., *Arizona Center for Disability Law v. Allen*, [197 F.R.D. 689](#) (D. Ariz. 2000) (holding that "a P & A is the final arbiter of probable cause for the purpose of triggering" its investigative authority. *Id.* at 693).

⁵ See [42 C.F.R. § 51.2](#); [45 C.F.R. § 1386.19](#) (defining "abuse" to include "the use of bodily or chemical restraints which is not in compliance with federal and state laws and regulations" and "any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue.")

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- MDLC met with AMRTC leadership at the facility on October 1, 2015. At that time, MDLC staff toured the hospital, and observed patients and staff in the hospital units.
- In a subsequent visit on February 11, 2016, MDLC interviewed nine patients at the facility to learn more about their experience with restraint and seclusion, and the treatment that they were receiving. MDLC also obtained written consent from these patients to request their records.
- Following these interviews, MDLC requested and reviewed restraint and seclusion records for eight patients. MDLC reviewed a total of 38 restraint and seclusion incidents. Eight incidents involved both restraint and seclusion, 27 involved restraint only, and three involved only seclusion. For each incident, MDLC documented specific data, including time of day the incident occurred, length of the incident, the names of staff and medical practitioner involved, and whether other interventions were attempted before the restraint or seclusion.

During the course of MDLC's investigation, the Centers for Medicare & Medicaid Services (CMS) conducted recertification surveys of AMRTC. CMS's surveys found multiple deficiencies, and concluded that AMRTC did not meet the Medicare Conditions of Participation. CMS notified AMRTC that it was planning to terminate AMRTC's Medicare Provider Agreement due to non-compliance. To prevent this loss of federal funding, AMRTC entered into a "System Improvement Agreement" with CMS in April 2016. As part of that agreement, AMRTC is required to develop and implement a "Corrective Action Plan" that will change a variety of hospital policies and procedures. MDLC requests that as part of this effort, AMRTC and CMS take MDLC's recommendations into account when crafting future hospital policy in the corrective action plan.

MDLC appreciates the cooperation, time commitment and assistance of AMRTC and DHS staff, who have provided requested data, answered questions, arranged visits with clients, and facilitated review of client records. MDLC's investigation resulted in the findings and recommendations detailed below.

Findings and Recommendations

Finding # 1 – The Current Restraint and Seclusion Policy Lacks Clear Guidance to Staff and Patients.

a. The policy lacks definitions.

MDLC reviewed AMRTC's current restraint and seclusion policy entitled "Adult Mental Health Seclusion or Restraint."⁶ The policy states that restraint and seclusion "may only be used as a

⁶ Minnesota Department of Human Services, Adult Mental Health, "Seclusion or Restraint," Policy No. 16673, Effective Date July 10, 2015.

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last resort for the management of aggressive, violent, or self-destructive behavior.” But the policy does not define what constitutes a “last resort;” it does not define “aggressive, violent or self-destructive behavior,” and it does not identify de-escalation techniques or supportive interventions to be used prior to initiating restraint or seclusion.

b. The policy is not clear regarding time and its limits.

Moreover, the policy is confusing with respect to the length of time that an individual may be in seclusion or restraint. Because of the harmful nature of restraint and seclusion, these procedures should be minimized and “discontinued at the earliest possible time.”⁷ In accordance with federal regulations, the policy states that seclusion should last no more than four hours, and restraint should last no more than two hours. However, the policy then states that both seclusion and restraint may be extended, but does not provide clear direction for when an extension should occur. The policy does not explain when seclusion should be extended, and states that restraint may be extended if “behaviors continue to meet criteria.” This vague language creates confusion and does not provide clear guidance for when a restraint or seclusion may go beyond the proscribed time limits.

c. The policy does not conform to best practices.

AMRTC’s policy does not conform with current best practices set forth in Minnesota Statutes Section 245D or Minnesota’s new Positive Support Rules. While AMRTC does not fall within the scope of 245D or the Positive Support Rules because it is not a licensed facility under Minnesota Statutes Section 245A, DHS has acknowledged that these rules represent best practices for individual with disabilities and promote a safe and healthy treatment environment.⁸ Minnesota Statutes Section 245D sets forth protection standards for the use of restraint and seclusion for home and community-based waiver providers. These standards prohibit the use of restraint and seclusion, with a limited exception for manual restraint in emergency situations. The current AMRTC policy goes beyond this. Moreover, the new Positive Support Rules, set forth in Minnesota Rules Chapter 9544, govern home and community-based waiver providers as well as all DHS licensed providers when serving individuals with developmental disabilities. These rules adopt the 245D protections standards, and also require facilities to implement positive support strategies and person-centered principles.

⁷ 42 C.F.R. § 483.12(e)(9)

⁸ Minnesota Department of Human Services, *Statement of Need and Reasonableness Proposed New Permanent Rules Governing Positive Supports, and Prohibitions and Limits on Restrictive Interventions* (December 15, 2014)

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Recommendation: Update Restraint and Seclusion Policy So That It Corresponds with Community Treatment Standards.

AMRTC should update its restraint and seclusion policy so that it parallels the requirements of Minnesota Statutes Section 245D and the Positive Support Rules. AMRTC's new policy should contain clear definitions of when restraint and seclusion may be used, and should specifically define what constitutes an "imminent risk of harm." The policy should also clearly set forth when restraint and seclusion must cease. Adopting these standards would not only ensure that AMRTC uses best practices for the treatment of people with disabilities, but would acclimate patients to the standard of care that they can expect to encounter when they are discharged to the community.

Finding #2 - Debriefing Following Restraint and Seclusion Incidents Is Insufficient.

The use of restraint and seclusion is a traumatic process that can negatively impact the physical and mental well-being of patients and staff.⁹ In order to maintain a safe and healthy treatment environment and minimize the damage done to both patient and staff, a restraint and seclusion protocol should include a "debriefing process" that discusses the incidents and works on reestablishing the therapeutic bond between the patient and staff.

The current restraint and seclusion policy calls for "staff debriefing . . . to discuss what went well or what could be learned from the event and improved upon for future events." However, the policy does not require any type of debriefing with the patient. AMRTC's "Seclusion/Restraint Record" form does call for patient input when deciding what changes should be made to the Vulnerability Risk Reduction Plan (VRRP) and the Comprehensive Treatment Plan (CTP) following the restraint or seclusion incident. Nevertheless, none of the records that MDLC reviewed showed patient involvement in the debriefing process.

The "Seclusion/Restraint Record Form" was included in the documentation in 14 of the 38 incidents that MDLC reviewed. All of these forms contained minimal information about what type of changes would be made to the VRRP and CTP in response to the restraint or seclusion incident. Ten of the forms simply stated that VRRP and CTP had been "updated." It does not appear that the serious consideration was given to how treatment could be improved to prevent future restraint and seclusion incidents.

Patients also reported during interviews with MDLC staff that they were not part of the debriefing process. None of the nine patients reported that they participated in debriefing with staff following restraint or seclusion incidents, nor did they discuss the restraint and seclusion incidents with staff members in group or individual treatment settings. For these patients,

⁹ See Lori Aschraft & William Anthony, *Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services*, 59 PSYCHIATRIC SERVICES 1198 (Oct. 2008) (citing various scientific studies documenting the traumatic effect of restraint and seclusion).

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restraint and seclusion incidents occurred, and then were quickly disregarded and ignored. The traumatic nature of these events was not acknowledged by staff.

Recommendation: AMRTC Should Institute a Robust, Meaningful Debriefing Process That Includes Staff and Patients.

AMRTC should take steps to minimize the effect of traumatic restraint and seclusion incidents. A comprehensive and person-centered debriefing process should occur that allows both patients and staff to discuss what lead to the incident, and what can be done to prevent similar events from occurring in the future. AMRTC's debriefing policy should incorporate aspects of the Minnesota Security Hospital's restraint and seclusion debriefing policy into its own practice. The MSH policy notes that debriefing is necessary in to order re-establish a therapeutic alliance with the patient and counsel the patient involved for any trauma that may have resulted from the incident.

AMRTC should adopt a debriefing process that identifies actions that patient and staff could do in the future to prevent further restraint and seclusion incidents. Moreover, the debriefing process should identify specific changes that were considered and that will be made to the patient's treatment plan following the restraint and seclusion incident. Because the use of restraint and seclusion may represent a breakdown of the patient's treatment plan, staff should consider changes to the treatment plan to prevent future restraint and seclusion incidents, and document the process and decisions reached.

Finding #3 – Patients' Concern about Lack of Treatment Was Consistent with CMS Findings.

MDLC's investigation focused on the use of restraint and seclusion at AMRTC. MDLC did not review patient treatment records, nor interview doctors, nurses or other staff about treatment protocols. Nevertheless, recent findings from the CMS recertification surveys are consistent with information discovered during MDLC's investigation that suggests patient treatment at AMRTC needs to be improved.

CMS's recent surveys of AMRTC revealed the use of rote treatment plans that did not include individualized goals and assessments. CMS found that multiple patient treatment plans "contained generic interventions that were normal functions of a professional discipline and not individualized to the patient."¹⁰ CMS concluded that patient treatment plans failed to identify "patient-centered short-term goals stated in observable, measurable, behavioral terms," and

¹⁰ Department of Health and Human Services Centers for Medicare & Medicaid Services, "Statement of Deficiencies and Plan of Correction for the Anoka Metro Regional Treatment Center," at 28 of 34, October 23, 2015.

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failed to identify long-term treatment goals.¹¹ CMS concluded that the failure to identify specific short- and long-term goals “hampers the treatment team’s ability to assess changes in patient’s condition as a result of treatment interventions and may contribute to failure to modify plans in response to patient’s needs.”¹²

During interviews with MDLC staff, patients expressed dissatisfaction with the amount and quality of treatment that they received at the facility, consistent with CMS’s findings. For example, one patient reported that s/he was “not really getting anything” out of treatment, and that “all [staff] do is give meds.” The patient reported that group therapy was the “same thing over and over.” Another patient described his/her treatment as “going to the library” and “watching TV.” This patient could not identify the specific staff or providers s/he was working with.

Dissatisfaction with treatment may be linked to a flawed discharge process that inappropriately traps patients at AMRTC. AMRTC is an acute psychiatric inpatient treatment center designed to stabilize individuals in crisis. Nevertheless, the effects of Minnesota’s “48-hour law” as well as a shortage of appropriate community placements has clogged the discharge process. As a result, in January 2016, nearly one half of the AMRTC population no longer met a hospital level of care, but remained at the facility because they lacked an appropriate community placement.¹³

While meeting with MDLC, AMRTC leadership noted that issues with discharge arise in part due to the changing population at the facility. AMRTC leadership explained that between 30-40% of the population were individuals who were sent to AMRTC because of the “48-hour law.” The law provides that incarcerated individuals who are civilly committed because they are incompetent to stand trial must be admitted into a state facility within 48 hours of the civil commitment.¹⁴ AMRTC leadership reported that many of these individuals may not actually require psychiatric care because they have diagnoses such as anti-social personality disorder. Moreover, once these individuals have completed treatment, they are difficult to place in the community because of their criminal histories.

¹¹ Department of Health and Human Services Centers for Medicare & Medicaid Services “Statement of Deficiencies and Plan of Correction for the Anoka Metro Regional Treatment Center,” at 6-7 of 27, October 23, 2015.

¹² Department of Health and Human Services Centers for Medicare & Medicaid Services “Statement of Deficiencies and Plan of Correction for the Anoka Metro Regional Treatment Center,” 2 of 27, October 23, 2015.

¹³ Chris Serres, *Anoka state mental hospital violated basic rules for patient care, feds say*, MINNEAPOLIS STAR TRIBUNE, January 16, 2016, available at <http://www.startribune.com/anoka-state-mental-hospital-violated-basic-rules-for-patient-care-feds-say/365551291/>

¹⁴ Minn. Stat. 253b.10, subd. 1.

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September 27, 2016
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Recommendation: AMRTC Should Improve Its Treatment and Discharge Processes.

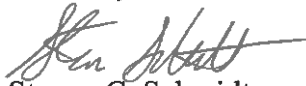
AMRTC should continue and increase its efforts to improve treatment options and discharge planning, including increasing efforts to build connections between AMRTC staff, county social services agencies, and private providers. MDLC recognizes that the intersection between these agencies is complex, and that discharge problems at AMRTC are related to the shortage in suitable housing for Minnesotans with disabilities. Nevertheless, AMRTC must work to establish these connections so that private providers and counties are more willing and prepared to serve so-called “difficult” clients.

Conclusion

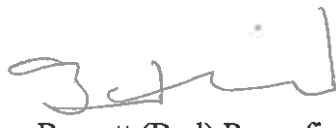
MDLC recognizes that AMRTC has made strides in reducing the use of restraint and seclusion at the facility in recent years. Nevertheless, additional efforts must be made. As AMRTC reforms its operations through the “System Improvement Agreement” with CMS, it is essential that restraint and seclusion processes and procedures be improved. AMRTC should re-write its restraint and seclusion policy to reflect best practices. Moreover, AMRTC should improve its debriefing procedure to minimize the traumatic effects of restraint and seclusions incidents. Finally, AMRTC should improve its treatment options and discharge procedures to create a more stable, patient-friendly environment. A concerted effort in all of these areas will enable AMRTC to provide essential, high quality psychiatric treatment for Minnesotans in need of care.

We would welcome the opportunity to discuss this letter with you. We believe that it is important to continue a dialog around these issues to ensure that improvements are made to the care and treatment provided at AMRTC. Please let us know if you are willing to meet us in the near future to discuss these issues. Thank you for your attention to this letter.

Sincerely,



Steven C. Schmidt
Staff Attorney



Barnett (Bud) Rosenfield
Supervising Attorney

SCS:nb

cc: Emily Johnson Piper, Commissioner, Minnesota Department of Human Services
Amy Akbay, General Counsel, Minnesota Department of Human Services
Beth Sullivan
Nadine Renbarger, Associate Regional Administrator, Centers for Medicare and Medicaid Services
Pam Thomas, Manager, Non-Long Term Certification and Enforcement Branch, Centers for Medicare and Medicaid Services
Roberta Ophem, Ombudsman for Mental Health and Developmental Disabilities



**MID-MINNESOTA LEGAL AID
MINNESOTA DISABILITY LAW CENTER
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**INVESTIGATIVE REPORT:
RESTRAINT AND SECLUSION AT THE
MINNESOTA SECURITY HOSPITAL**

July 29, 2015

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INTRODUCTION

The use of restraints and seclusion, once common in mental institutions, is now understood to be a damaging process for patients and the staff serving them. “Seclusion and restraints have no therapeutic value, contribute to human suffering, and have frequently resulted in severe emotional and physical harm, and death.”¹ Restraint and seclusion practices “are widely acknowledged to be violent, stressful, and humiliating incidents, both for patients and for the staff members imposing them.”² The use of restraints puts patients at risk for physical injury and death; asphyxia, aspiration and cardiac events are all possible results of the use of restraint.³ Restraint or seclusion should never be used, except to prevent imminent, serious physical harm:

“[S]eclusion and restraint are safety measures, not treatment, and they should never be part of standard treatment for someone’s condition. Their use—particularly when it is recurrent or protracted—represents a treatment failure and should be addressed as such.”⁴

In the last several years, state licensing authorities, the Minnesota Legislative Auditor, and numerous media reports have raised alarm about the use of restraint and seclusion at facilities operated by the Minnesota Department of Human Services (DHS), including the Minnesota Security Hospital (MSH). In 2009, a federal lawsuit was filed on behalf of individuals with developmental disabilities who were unjustifiably restrained and secluded in Minnesota Extended Treatment Options (METO), in violation of their civil rights.⁵ The case settled, and a Court Monitor was appointed to oversee implementation of the settlement, including reform of the state’s use of restraint and seclusion. On October 17, 2014, Court Monitor David Ferleger issued a report entitled *Restraint Chair and Seclusion Use at AMRTC and MSH: Phase 1 Review*,⁶ finding that, despite the terms of the *Jensen* settlement and a DHS commitment to eliminate restraint and seclusion, MSH continues to use these aversive practices.⁷

The Court Monitor’s Report caught the attention and concern of Mid-Minnesota Legal Aid’s Minnesota Disability Law Center (MDLC). Mid-Minnesota Legal Aid is designated by gubernatorial executive order as the federal Protection and Advocacy (P & A) System for the state of Minnesota and performs this function through the MDLC. Congress has enacted statutes which grant P & A systems the authority to investigate incidents of abuse and neglect that are

¹ *Position Statement 24: Use of Seclusion and Restraints*, MENTAL HEALTH AM. (approved Mar. 5, 2011), <http://www.mentalhealthamerica.net/positions/seclusion-restraints>.

² Stephen Haimowitz, et al., *Restraint and Seclusion: A Risk Management Guide*, (Sept 2006), http://www.ndrn.org/images/Documents/Issues/Restraint_and_Seclusions/NDRN_Risk_Management_Guide.pdf.

³ See W.K., Mohr et al., *Adverse Effects Associated with Physical Restraint*. 48CAN. J. PSYCHIATRY 330–33 (2003).

⁴ *Restraint and Seclusion*, BAZELON CTR. FOR MENTAL HEALTH L. <http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment/Restraint-and-Seclusion.aspx> (last visited July 1, 2015).

⁵ See *Jensen v. Minn. Dep’t of Human Servs.*, No. 09-cv-1775-DWF-FLN, 2011 WL 6178845, at *1 (D. Minn. Dec. 5, 2011).

⁶ *Restraint Chair and Seclusion Use at AMRC and MSH: Phase 1 Review*, *Jensen*, 2011 WL 6178845 (2013) (No. 09-cv-01775-DWF-FLN), ECF No. 236.

⁷ *Id.* at 10.

reported to the system.⁸ Unnecessary restraint and seclusion meet the definition of abuse as defined by federal law,⁹ and MDLC determined that the Court Monitor's Report established probable cause that incidents of abuse and neglect have occurred at MSH. MDLC then initiated this investigation pursuant to our authority and responsibility under federal law.

MDLC appreciates the cooperation, time commitment and assistance of MSH and DHS staff, who have provided requested data, answered questions, arranged visits with clients, and facilitated review of client records. In the interest of cooperation, MDLC has provided DHS and MSH administrators with a copy of the draft report, and has taken their comments, concerns and suggestions into consideration in producing the final report.

MDLC's investigation resulted in a number of findings and recommendations that are detailed below. MDLC's immediate objective in making these recommendations is to identify additional steps that are needed to reduce the use of restraint and seclusion at MSH, with a goal of eliminating these harmful techniques. Implicit in this effort is improved treatment geared toward discharge, which would reduce the frustration, rooted in hopelessness, expressed by so many who have been restrained and secluded. As DHS has forthrightly stated:

“We commit not only to following legal and regulatory requirements limiting the use of seclusion and restraint as a provider of service, but also to creating a broader culture that honors the trust placed in us both as a provider and as a department responsible for the administration and oversight of many of the services that support citizens...”¹⁰

BACKGROUND

Summary of Public Policy Shifts Affecting the Mentally Ill and Dangerous Population and the Use of Restraint and Seclusion at MSH.

The first “Asylum for Dangerous Insane” opened on the St. Peter campus in 1911. In 1982, the current Minnesota Security Hospital (MSH) building opened. Bonding was approved in 2014 to upgrade the physical plant and add units. MSH is licensed by the Minnesota Department of

⁸ Federal law provides that P & A systems may conduct investigations when there is probable cause to believe that incidents of abuse and neglect have occurred. *See* [42 U.S.C. §§ 10805\(a\)\(1\)\(A\), 15043\(a\)\(2\)\(B\)](#) (2012). The law defines “probable cause” as “reasonable grounds for belief that an individual has been, or may be, subject to abuse or neglect.” [42 C.F.R. § 51.2](#) (2015); *see also* [45 C.F.R. § 1386.19](#). As the state's P & A system, the MDLC is the arbiter of whether there is probable cause to conduct an abuse and neglect investigation. *See, e.g., Arizona Center for Disability Law v. Allen*, [197 F.R.D. 689](#) (D. Ariz. 2000) (holding that “a P & A is the final arbiter of probable cause for the purpose of triggering” its investigative authority. *Id.* at 693).

⁹ *See* [42 C.F.R. § 51.2](#); [45 C.F.R. § 1386.19](#) (defining “abuse” to include “the use of bodily or chemical restraints which is not in compliance with federal and state laws and regulations” and “any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue.”)

¹⁰ *Respect and Dignity Practices Statement*, MINN. DEP'T HUM. SERVICES (June 20, 2013), <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6756-ENG>.

Health (MDH) as a supervised living facility and by DHS as a residential facility for persons with mental illnesses.¹¹

The St. Peter Campus includes the MSH, Transition Services, the Forensic Nursing Home and portions of the Minnesota Sex Offender Program. MSH itself is divided into 11 separate units, each with a different treatment focus. As of July 1, 2014, there were 743 direct care full-time employees in State Operated Forensic Services. A description of the structure and staff at MSH is found in Appendix B of this Report.

Commitment to MSH as mentally ill and dangerous (MID) requires that a person be mentally ill as defined in the statute, and, as a result of that mental illness, present a clear danger to the safety of others, as demonstrated by an overt act causing or attempting to cause serious physical harm to another, and there is a substantial likelihood of future such harm.¹² For example, a person who committed a series of serious assaults, acting while governed by a system of delusional beliefs, might be committed as MID rather than imprisoned.

Commitment as mentally ill and dangerous has not always meant that a person must go to MSH. Previously, less restrictive alternatives to MSH placement were more easily available for individuals committed as MID.¹³ However, inclusion of sex offenders in the MSH population in the 1990's greatly affected policies pertaining to MID patients. Under current law, individuals who are committed as MID must be committed to a "secure treatment facility," and MSH is the only "secure treatment facility" in the state.¹⁴

As the patient population at MSH shifted to include more sex offender commitments, the use of seclusion changed from "programmatically" seclusion for behaviors related to one's mental illness to "protective isolation" for harmful conduct not the result of one's mental illness.¹⁵ As noted by the Legislative Auditor, the distinction between the two types of seclusion eroded over time, and MSH increasingly used protective isolation to control mental illness symptomatology and related behavior. Under the rubric of protective isolation, mentally ill persons could be kept in seclusion for weeks and even months.¹⁶

Investigations of MSH from 2002 to 2011 have consistently found that patients were being secluded for lengthy periods of time without appropriate clinical orders or adequate checks and balances on usage.¹⁷ For example, a DHS licensing order from 2011 "highlighted one

¹¹ See *DHS Licensing Look-up*, MINN. DEP'T HUM. SERVICES, <http://licensinglookup.dhs.state.mn.us> (last visited July 1, 2015).

¹² MINN. STAT. § 253B.02, subd. 13 (2014).

¹³ See MINN. STAT. § 253B.18, subd. 1 (1982) (allowing for the commitment of person who is MID to a "treatment facility" other than the Minnesota Security Hospital).

¹⁴ See MINN. STAT. § 253B.18, subd. 1 (2014).

¹⁵ OFFICE OF THE LEGISLATIVE AUDITOR, EVALUATION REPORT: STATE-OPERATED HUMAN SERVICES 63 (Feb. 2013) [hereinafter 2013 OLA REPORT], available at <http://www.auditor.leg.state.mn.us/ped/pedrep/sos.pdf>.

¹⁶ Procedural protections for patients placed in protective isolation were implemented as the result of a patient lawsuit. See *Reome v. Gottlieb*, 361 N.W.2d 75 (Minn. Ct. App. 1985).

¹⁷ See Appendix C of this report for a summary of reports addressing safety, staffing, and seclusion and restraint at MSH.

particularly troubling incident where a patient was not only placed in protective isolation for months, but was forced to sleep on a concrete slab without a mattress for 25 days.”¹⁸

In December 2011, DHS Licensing released a report of an investigation of restraint and seclusion at MSH that resulted in a Determination of Maltreatment and Order of Conditional License.¹⁹ MSH was required to immediately rewrite its policies regarding the use of restraint, seclusion, protective isolation and security restraint to conform to regulatory and best practice standards. MSH abandoned its use of protective isolation and issued a revamped seclusion and restraint policy, again amended in January 2014 and February 2015 as a result of continuing pressure from Licensing.²⁰ Meaningful implementation of the terms of the conditional license continues to be a challenge for MSH, which has had its conditional status continued until 2016.

In addition to the December 2011 licensing report, other investigations and reports regarding the use of restraint and seclusion and the overall conditions at the MSH have criticized MSH practices. These reports are summarized in Appendix C.

Current Restraint and Seclusion Policy at MSH

The current MSH restraint and seclusion policy²¹ defines what constitutes a “restraint” or “seclusion.” The policy explains that a restraint is “any physical device that limits the free and normal movement of body and limbs as defined in Minnesota Rule 9520.0510, subp. 25.” The policy sets forth eleven categories of restraint:

- Manual restraint – placing hands on an individual for the purposes of restricting movement
- Velcro Restraint - wrist, ankle and arm
- Handcuffs
- Body Wrap – upper body and ankle
- Spit hood, which is later defined in the policy as a “hood placed over patient’s head to prevent contamination and risk of infection in situations where the patient is actively spitting.
- Transport Device – medical device used for the purpose for moving a patient from one area to another, i.e., medical gurney or backboard. The patient will be restrained to the device to maintain safety.
- Posey Ambulatory Belt- used in transporting patient in Reeves stretcher
- Shield, which is later defined in the policy as “a device used as a barrier by staff to protect staff and other patients.”

¹⁸ 2013 OLA REPORT, *supra* note 15, at 64 (citing DIV. OF LICENSING, MINN. DEP’T HUMAN SERVS., DHS LICENSING DETERMINATION OF MALTREATMENT, LICENSING REPORTS 20103702,20103327 8–9 (December 22, 2011).

¹⁹ DIV. OF LICENSING, MINN. DEP’T HUMAN SERVS., DHS LICENSING DETERMINATION OF MALTREATMENT, LICENSING REPORTS 20103702,20103327 8–9 (December 22, 2011).

²⁰ STATE OPERATED FORENSIC SERVS., MINN. DEP’T OF HUMAN SERVS., PROCEDURE NUMBER 10005 (08/21/2014, amended 02/13/2015 and 07/01/2015) [Hereinafter “MSH RESTRAINT AND SECLUSION POLICY”]. A copy of the most recent Restraint and Seclusion Policy is included as Appendix A to this report.

²¹ *Id.*

- Mobile restraint – one point or two point
- Restraint chair – up to six point
- Restraint to bed – up to four point

The policy defines seclusion as the “involuntary removal into a separate room which prevents social contact with other persons as defined in Minnesota Rule 9520.0510, subp. 26. Seclusion involves a locked room or preventing the patient from physically leaving an area.” The policy limits the use of restraint and seclusion at MSH to instances where it is “necessary to protect the patient or others from imminent risk of harm.” The policy defines “imminent risk” as a “behavior that is likely to cause harm to self or others that is highly likely to occur in the immediate near future.” The policy also requires that “the minimum amount of intervention will be utilized for the shortest period of time to meet safety concerns.”

The MSH policy includes a variety of safeguards to limit the extent to which restraint and seclusion may remain in place. All use of restraint and seclusion must be authorized by a registered nursing or medical practitioner, and an order written by a medical practitioner must be obtained. At the initiation of the restraint or seclusion, the medical practitioner must set forth “release criteria” that state when the restraint and seclusion must be discontinued. The intervention must be discontinued as soon as the release criteria are met. Patients must also be continuously monitored during the restraint and seclusion by a registered nurse or other staff.

After the incident has ended, the policy requires a “debriefing session” where the patient and available staff discuss the incident. Goals of the debriefing include identifying what led to the incident and what could have been handled differently, and re-establishing a therapeutic alliance with the patient. If the patient does not participate, a staff person attempts to establish communication between the patient and team.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Investigation Process

In a February 24, 2014 letter to Carol J. Olson, Executive Director of Forensic Treatment Services, MDLC outlined its role as the federal Protection and Advocacy agency and its duty under federal law to investigate incidents of abuse and neglect at facilities around the state.²² The letter set forth that the inappropriate use of restraint and seclusion is considered “abuse” and highlighted the federal Court Monitor’s report of the ongoing use of restraint and seclusion at MSH. The letter explained that MDLC would be investigating whether abuse and neglect related to the use of restraint and seclusion had occurred at MSH.

MDLC requested records and documents regarding the use of restraint and seclusion at MSH. MDLC sought policies and procedures for the use of restraint and seclusion at the MSH. MDLC received the names and contact information of every individual subjected to restraint and seclusion from June 1, 2011 to March 14, 2014. Ninety-eight individuals were both restrained

²² See [42 U.S.C. § 10805\(a\)\(1\)\(A\)](#) (2012); [42 U.S.C. § 15043\(a\)\(2\)\(B\)\(i\)](#); [42 C.F.R. § 51.2](#) (2015); [45 C.F.R. § 1386.19](#).

and secluded at MSH. Another 42 individuals were subjected to restraint only, and 17 individuals were subjected to seclusion only.²³ After analyzing these numbers, MDLC concluded that, given its limited resources, it would not be able to interview each individual who had been subject to restraint and/or seclusion. MDLC decided to focus on a select number of individuals who were being specifically tracked by DHS staff because of a high incidence rate of restraint and seclusion.

Document Review

In May 2014, MDLC requested that DHS provide records related to the last 10 restraint and/or seclusion incidents for 10 patients.²⁴ MDLC also requested records for the last 10 incidents for another patient in August 2014. In total, MDLC examined 103 incidents of 11 patients. Eleven of the incidents involved seclusion only, 45 of the incidents involved restraint only, and 47 incidents involved both restraint and seclusion.

For each incident, MDLC documented specific data such as time of day, length of the incident, the names of staff and medical practitioner involved, and whether other interventions were attempted. MDLC also reviewed individual treatment plans in place at the time of the restraint and seclusion incidents, as well as progress notes and patient medical records generated at the time of the incident.

MDLC conducted in-depth reviews of medical and treatment records for 5 of the 11 patients. These reviews included examining individual abuse prevention plans, individual and master treatment plans, relapse prevention plans, quarterly reports, staff progress notes, and other treatment records. The purpose of these reviews was to determine whether a lack of appropriate treatment contributed to restraint and seclusion incidents, and whether changes to treatment were made in response to restraint and seclusion incidents.

Patient Interviews

On May 15, 2014, MDLC interviewed 14 MSH patients who had been restrained and/or secluded. MDLC sought to gain the patients' perspectives on why they had been subjected to frequent restraint and seclusion, as well as the treatment that they receive. The discussion included the patients' views of what their treatment consisted of, whether there were changes to treatment after the use of restraint and seclusion, and what alternatives to restraint and seclusion were utilized or available. Patients were asked what they would do to address the situations that ultimately resulted in restraint and seclusion. Patients also signed authorizations to share their records with MDLC.

²³ It should be noted that these numbers are not the same as the numbers that were reported in the Court Monitor's Report. It is unclear whether the Court Monitor's Report considered restraint and seclusion data regarding individuals who had been committed to MSH as "mentally ill and dangerous" (MID). Individuals with MID commitments constitute the majority of patients within MSH, and subsequently the majority of patients who have been subjected to restraint and seclusion at the facility.

²⁴ Some of the patients that MDLC contacted on May 6, 2014 chose not to meet with MDLC staff. Other patients did not have a history of restraint and seclusion incidents that would allow for a meaningful review.

On July 22, 2014, MDLC staff returned to MSH to conduct additional interviews with patients, which focused in more detail on the treatment that patients were receiving, whether changes to treatment plans had impacted restraint and seclusion, and patients' ideas and recommendations about how treatment could be more effective. MDLC also examined Units 800 and 900 of MSH.²⁵ MSH staff provided MDLC staff with a tour of both units, and provided answers to questions about staffing levels, the treatment modalities and philosophies of the units, and structural facility and day-to day operations.

On November 17, 2014, MDLC staff visited MSH to meet with additional patients and observed Units 200 and 300. MDLC staff spoke directly with staff and patients regarding recent changes at the hospital and the implementation of person-centered planning. In 2015, MDLC also visited several MSH patients at their request.

Information from MSH Staff

In an effort to achieve a full understanding of the state of affairs at MSH, MDLC staff sought to interview a variety of MSH staff members. MDLC staff made several efforts to contact representatives from AFSCME Local 404, the union that represents that majority of MSH employees, but did not receive a response. In the alternative, MDLC reviewed minutes from Local 404 union meetings and conducted brief informal interviews of staff members during its visits to MSH. Questions in these interviews focused on restraint and seclusions practices, unit treatment programs, implementation of person-centered planning, and general questions about the current operation of MSH.

MDLC also had a telephone conference with Executive Director of Forensic Treatment Services Carol Olson and DHS Deputy Commissioner Anne Barry on November 5, 2014 for the purpose of clarifying data, policies and expected changes in delivery of treatment at MSH. In addition, information from DHS has been provided by email communication.

KEY FINDINGS

A. The Implementation of the Current MSH Seclusion and Restraint Policy Continues to Fall Short of Acceptable Outcomes Established by DHS (pp. 12-22).

1. The facility's use of restraint and seclusion has fluctuated within a limited range since the policy was changed in 2012, but has not demonstrated a consistent downward trend.
2. Units 800 and 900 account for the majority of restraint and seclusion incidents; furthermore, a small minority of patients account for most restraint and seclusion incidents.

²⁵ MDLC examined Units 800 and 900 because the highest use of seclusion and restraint at MSH occurred on these units, and examined Units 200 and 300 for purposes of comparison, given their significantly lower rates of seclusion and restraint. Appendix B contains a description of each MSH unit.

3. In practice, the use of restraint and seclusion does not uniformly conform to MSH's written policies and procedures and, in some cases, represents substantial violations of these policies and procedures. These violations include difficulty identifying antecedent behaviors; belated attempts to use less restrictive measures; use where there was not a risk of imminent harm; and a release process that did not consistently follow the policy.

B. MSH Fails to Provide Proper Debriefing and Adjustment of Behavior Plans in Response to the Use of Restraint and Seclusion (pp. 23-28).

1. The patient debriefing process that is called for in the restraint and seclusion policy generally lacks effective patient involvement, meaningful behavior analysis and treatment changes designed to reduce future incidents.
2. Behavior management reviews and clinical reviews of patient treatment are not patient centered, often do not identify and implement positive changes aimed at reduction in restraint and seclusion, and lack a method of tracking the effectiveness of the recommendations.

C. While Improvements Have Been Made in Staff Training, There is No Concerted Plan to Provide Ongoing, Intensive Training that Also Involves the Patient in the Process (pp. 28-31).

1. The frequency of training on topics related to the use of restraint and seclusion training is insufficient, particularly compared to training in other areas.
2. Despite the implementation of person-centered policies, patients are not involved with staff training.

D. The Patients Most Frequently Restrained and Secluded Receive Inadequate Mental Health Treatment (pp. 31-40).

1. Patients at MSH, including patients most frequently restrained and secluded, have an average of just over one hour per day of scheduled therapeutic activities, including mental health treatment-related meetings and groups.
2. MSH relies heavily on security counselors both to deliver daily treatment and to keep order on the units. This represents a conflict of roles identified by patients as undermining their treatment.
3. Although treatment programming and implementation should primarily be the responsibility of mental health professionals, there are inadequate numbers of

mental health professionals at MSH trained to implement positive therapeutic procedures.

4. There is not enough individual therapy available from mental health professionals on an ongoing basis.
5. MSH does not have strong relationships with treating professionals in the greater community who have the expertise to work on targeted treatment issues for patients who are repeatedly restrained or secluded.

KEY RECOMMENDATIONS

A. Successful Implementation of the MSH Restraint and Seclusion Policy Requires a Greater Effort by MSH Staff to Identify and Correct Problems With Its Usage (pp. 12-22).

1. MSH Needs to Improve the Accuracy of Tracking Restraint and Seclusion Incidents.

- In order to determine whether efforts to reduce restraint and seclusion are working, MSH should ensure that the data collected is accurate and complete.
- All MSH staff should have full knowledge of the restraint and seclusion policy, understand what events need to be documented, and how to do so in a professional manner.

2. A uniform policy governing the use of restraint and seclusion and the application of positive treatment interventions should apply to all patients at MSH.

- The current policy does not comply with DHS's new positive support strategies rule for persons with developmental disabilities.
- Because patients who have been committed to MSH as Mentally Ill and Dangerous may also be diagnosed with a developmental disability, all staff will need to know what requirements apply to which patients.
- Philosophical differences between positive treatment and interventions and MSH policy should be reconciled. The positive support strategies rule for persons with a developmental disability outlaws use of the restraint chair as an abusive practice. However, this practice is still allowed for a person with mental illness, even though there is no evidence that it is less abusive for a person with a mental illness than for a person with a developmental disability

3. **MSH should implement a dispute resolution model which patients and staff can use to resolve potentially assaultive situations and corresponding use of restraint and seclusion.**

B. MSH Should Provide Proper Debriefing and Adjustment of Behavior Plans in Response to the Use of Restraint and Seclusion (pp. 23-28).

1. **MSH needs to create a respectful and effective patient debriefing process.**

- MSH should specifically require analysis of what the *staff* should have done better, including whether they have accurately identified supportive and less restrictive interventions and have timely implemented them.
- Debriefing should be done at a time when the patient is able to participate in the debriefing process, and staff with experience in behavioral analysis should be part of the debriefing process. Trauma counseling should be a separate process.
- The debriefing process should include wherever possible a patient support person, such as a peer specialist, or an individual from outside of MSH who can be with the patient in the process.

2. **Behavior management and clinical review committees should be accountable to the patients, particularly those who have been restrained or secluded.**

- DHS should ensure that the review committees evaluate the treatment team's implementation of a patient's treatment plan, in particular the review committee's recommendations. This should include whether staff were accurately trained in how to implement any new behavioral component of the treatment plan, and whether the patient was improperly restrained or secluded.
- The review committees should be required to keep and regularly analyze data on the success or failure of their recommendations, for both individual patients and for each MSH unit.
- Patients should be able to make treatment plan proposals and to appeal decisions regarding their treatment to these committees. This should include the opportunity for the patient to further appeal decisions to the forensic medical director. This is particularly important where there have been repeated instances of seclusion or restraint.
- MSH should add a step to the review process that will enable the staff and the patient to request and receive consultation with outside mental health professionals who have expertise in positive therapeutic procedures, with a

focus on evaluating possible positive behavioral approaches that have not been tried to reduce the use of restraint and seclusion.

C. Additional Training on the Correct Implementation of All Aspects of the Seclusion and Restraint Policy Is Needed at MSH (pp. 28-31).

1. MDLC supports the principle contained in the DHS Abatement Plan calling for more intensive training of staff, including training in scenarios about risk of imminent harm.

- This training approach should be shared with patients, eliciting their involvement in demonstrating what works for them.

2. MSH Staff should receive ongoing training by mental health professionals who can help them identify patient behaviors and symptoms indicating increasing agitation, and teach them how best to respond at critical junctures before de-escalation or restraint is called for.

- Staff should be required to be familiar with the behavior and treatment plans for every patient with whom they work.
- Unit supervisors and clinical staff serving each unit should ensure that every staff person has reviewed and understands behavior and treatment plans for every patient, even if staff members are not working on their regularly assigned unit, or if the patient is unfamiliar to them.

3. Particularly for those patients frequently restrained or secluded, MSH should contract with experts in the use of positive supports to work with individual patients and staff.

- Positive supports experts can help identify triggers to aggressive behaviors, provide different approaches to prevent aggressive behaviors, and practice identified interventions.

D. To Significantly Reduce Restraint and Seclusion, and to Create a Successful Environment for Patients and Staff, MSH Should Increase, Improve, and Individualize Its Mental Health Treatment (pp. 31-40).

1. MSH needs to implement more individual therapy using appropriate mental health professional staff in paid positions.

- While a helpful adjunct to a treatment plan, the current reliance on time-limited interns is not a sustainable solution for patients.

- Where a patient has difficulty with group therapy processes, individual therapy may also be a reasonable accommodation required under the Americans with Disabilities Act (ADA).
2. **MSH should hire additional psychologists, behavioral analysts and other mental health professionals in order to correctly develop and implement positive behavioral and treatment plans for each patient.**
- In the interest of better, more active patient treatment, MSH should review its dual use of security counselors as safety enforcers and treatment providers, and strongly consider separating differing job functions into different staff positions.
 - The frequency of psychiatric contacts with individual patients should be tied to the expectations set forth in individualized patient treatment plans the moment the person goes through admission; national experts have recommended at least monthly contact.
3. **DHS should enlist community professionals and provider resources to serve MSH patients, enabling provision of genuinely individualized patient treatment, and building pathways to acceptance into community programs.**
- Having more flexibility to individually tailor treatment will result in better outcomes at an earlier point in time and ultimately earlier discharge.
 - Establishing stronger relationships with community providers would also mean involvement of a broader range of uniquely qualified professionals for MSH to call on for more individualized testing, patient assessments and treatment. Building relationships and successfully working with patients has the potential to create patient pathways to acceptance into community services.

DISCUSSION OF FINDINGS and RECOMMENDATIONS

A. The Implementation of the Current Seclusion and Restraint Policy Continues to Fall Short of Acceptable Outcomes Established by DHS.

FINDING 1. The use of restraint and seclusion has fluctuated since January 2012, in part because at any given time, a small minority of high acuity patients account for most restraint and seclusion incidents.

MDLC analyzed data that it received from DHS regarding restraint and seclusion incidents that took place at MSH from January of 2012 until March 2015. Overall, the use of restraint and seclusion at MSH has fluctuated over the past three years. Restraint use reached high points in November of 2012 and again in February of 2014. The restraint chair was ordered 25 times in

each of these months. Seclusion use reached high points in August of 2012, with slight peaks again in February 2013, June 2014, and January 2015.

It is difficult to draw any firm conclusions regarding whether the use of restraint and seclusion has decreased since January of 2012. One issue affecting the accuracy of the data is the manner in which staff reported incidents of restraint and seclusion during different time periods. Minutes from the Hospital Review Board state that in the early months of 2012, staff members did not report hands-on contact used to place a patient in seclusion as a separate “restraint” incident.²⁶ This explanation for the lower numbers during that time period was also supported by Executive Director of Forensic Treatment Services Carol Olson and Deputy DHS Commissioner Anne Barry in a conversation with MDLC on November 5, 2014. Consequently, actual restraint numbers in these months may be higher than reported.

DHS State Operated Forensic Services provided data regarding the use of restraint and seclusion in its annual reports. For Fiscal Year 2013, graphs show that restraint hours went from a high of around 160 total hours in November 2012 to a low of around 20 in May 2013. In Fiscal Year 2014, the high was around 80 hours in February 2014; the low was around 5 hours in October 2014, a significant downward trend.²⁷ Seclusion hours ranged from around 275 hours in August 2012 to around 5 in October 2014.

The percent of patients restrained has vacillated from 7% in July 2012 to around 2% in February 2013, and up and down from 3.5% to 5% in FY2014. According to the Report, the Behavior Management Review Committee and Clinical Management Committee review the use of restraint and seclusion on a regular basis.²⁸ Percent of patients in seclusion has run the gamut from over 4% in August 2012 and June 2013, with lows of 2% in several months. The last reported month, June 2014, shows around 3% of patients being in seclusion.²⁹

DHS officials assert that restraint and seclusion have gone down in recent months since the implementation of person-centered training for all staff members in the fall of 2014.³⁰ However, restraint and seclusion data from the early months of 2015 do not show a substantial decrease from 2014, with approximately 19-25 hours of restraint per month. In fact, January 2015 saw total seclusion use of 107.48 hours, which was the highest figure since August 2012. There is no strong evidence that supports a causal connection between person-centered training and a permanent reduction in restraint and seclusion.

Despite inconsistent numbers, there are a few clearly identifiable trends in the MSH restraint and seclusion data. First, the data reveals that a small minority of MSH patients account for the vast majority of restraint and seclusion incidents. The percentage of patients restrained at MSH ranged from a low of 2.06 in September of 2014 to a high of 5.21 in January of 2014. The percentage of patients who were secluded ranged from a low of 1.18 in September 2014 to a high

²⁶ See Minutes of the Minnesota Security Hospital Review Board, 8 (Mar. 28, 2013).

²⁷ See STATE OPERATED FORENSIC SERVS., FISCAL YEAR 2014 ANNUAL REPORT 16–17 (2014) [Hereinafter “2014 ANNUAL REPORT”].

²⁸ *Id.* at 16.

²⁹ *Id.* at 18.

³⁰ MDLC Conversation with Deputy Commissioner Anne Barry and Executive Director of Forensic Treatment Services Carol Olson (Nov. 5, 2014).

of 3.64 in March of 2014. In a hospital population of approximately 330 patients,³¹ the number of patients restrained and secluded is in the teens, and sometimes single digits.

As discussed in more detail below, the steps taken to reduce restraint and seclusion incidents for this small patient population have been minimal. The majority of patient treatment plans, behavioral review plans, risk management plans and abuse prevention plans fail to timely and adequately identify and address the root causes of restraint and seclusion incidents, and consequently do not offer solutions to prevent these incidents from occurring in the future. The MSH restraint and seclusion and treatment policies do not have a proper response plan in place for high acuity patients who are exhibiting aggressive behaviors.

Consequently, restraint and seclusion episodes for many patients tend to occur in “waves” when the patient is experiencing high levels of mental distress. For example, in February of 2014, MSH staff recorded 55 incidents of restraint and seclusion for one patient. By contrast, the same patient had zero incidents in January 2014, and approximately 17 incidents in March 2014. For another patient, six of the nine incidents that MDLC reviewed occurred over the course of a 2.5 week period.

There appears to be a significant correlation between large monthly spikes in MSH’s restraint and seclusion data, and slow or ineffective responses for these patients who are experiencing “waves” of restraint and seclusion incidents. It is likely that MSH’s use of restraint and seclusion will increase again if the treatment needs of high acuity patients are not appropriately analyzed and timely responded to using best practices such as positive behavioral supports.

RECOMMENDATION 1: Continue and improve tracking of restraint and seclusion incidents, and systematically respond to those patients being frequently restrained.

In order to determine whether efforts to reduce restraint and seclusion are working, MSH should ensure that data collected on the use of restraint and seclusion is accurate. Training of MSH staff should include how to adequately document restraint and seclusion incidents, so that the monthly data is being collected on a consistent basis. All MSH staff should have full knowledge of the restraint and seclusion policy, and understand what events need to be documented.

MSH has taken a positive first step by identifying and monitoring individuals who account for the majority of restraint and seclusion incidents. However, MSH should also adapt its treatment protocols to prevent repeated aggressive behaviors that lead to multiple restraint and seclusion incidents for individual patients. Outside experts, particularly those trained in Positive Behavioral Interventions and Supports (PBIS) should be “on call” and available if a patient continues to be restrained. These experts can work with individual patients, and the staff assigned to assist them, in order to identify triggers, provide new ideas to prevent aggressive behaviors, and practice identified interventions.

³¹ This figure includes patients who are in the Competency Restoration Program, Special Needs Services, Young Adult and Adolescent Program and Transition Services. From January 1, 2013 to February 28, 2014, DHS also included the Forensic Nursing Home in the total hospital population and its restraint and seclusion data. As a result, the hospital population for these months was around 360.

FINDING 2: Unit 800 and 900 account for the majority of restraint and seclusion incidents.

Another trend evident from MSH restraint and seclusion data is that Units 800 and 900 account for the majority of restraint and seclusion incidents at MSH. Month-by-month figures reveal that Units 800 and 900 consistently had the highest number of patients who were restrained and secluded, and the most restraint and seclusion hours. For example, in January 2014, 11 patients at MSH were put into seclusion; 8 of these patients resided in Units 800 and 900. In February 2014, there were 14 documented incidents of restraint at MSH; 11 of the incidents occurred in Units 800 and 900. By comparison, other units at MSH had few to no incidents of restraint or seclusion. For example, from October of 2012 until September of 2014, Unit 300, known as “Rehabilitation and Recovery 1,” had only one incident of restraint and two incidents of seclusion. During that same time period, Unit 600, known as “Special Needs Services,” had three incidents of restraint and one incident of seclusion.

Anecdotal evidence from licensing complaints regarding Units 800 and 900, as well as patient and staff interviews, describe the atmosphere of Units 800 and 900 as tense and chaotic. One patient subjected to significant restraint and seclusion on Unit 800 explained that on Unit 800 he felt “set up for failure” and that he believed that staff on Unit 800 felt that restraint and seclusion was their “first choice.” Significantly, that patient did not experience a restraint or seclusion incident throughout 2014, when he resided on Unit 300. The patient explained that Unit 300 had a “calm” atmosphere, and that the change in environment was a principal reason that he had not had been restrained or secluded.³²

The unique structures of both Unit 800 and Unit 900 are also likely factors for the greater use of restraint and seclusion. Unit 800, known as the “Admissions and Crisis Care Unit,” previously combined new admissions to MSH with patients who have significant histories of aggressive behaviors and may be in crisis. Patients who exhibit aggressive behaviors on other units at MSH are commonly transferred to Unit 800.

Moreover, unlike some other units at MSH, Unit 800 does not offer a specific treatment focus, with programming linked to that focus. Rather, the goal of Unit 800 is primarily “stabilization.” The number of treatment groups offered on Unit 800 is minimal compared to the number of treatment groups on other units. The relatively independent operations of the various units at MSH and lack of consistency in programming across units also contribute to the large discrepancies in restraint and seclusion incidents between units.

Unit 900 presents its own unique set of challenges. Known as the “New Outlook Women’s (NOW) Unit,” it is the only women’s unit at MSH, and as such houses women with a wide variety of mental illness. Every woman who is committed to MSH is placed in Unit 900 for a minimum evaluation period of 60-90 days. For most patients, the stay is much longer. Consequently, women with a variety of treatment needs are housed together in a single environment. Women with severe mental illnesses are placed in the same environment as women who are ready to proceed to the transition services portion of the program but are waiting for an open spot in the transition unit. Unit 900’s current treatment and group model does not separate these patients.

³² Patient interview with MDLC (May 15, 2014).

DHS has made some recent adjustments to Unit 800 and 900 with the goal of improving the environment of these units. Most notably, MSH has reconfigured a patient care area into a 4-bed admission unit and intends to incorporate this model into its new hospital building.³³ Bonding for the new building was approved by the 2014 Legislature. When complete, the construction project will include two 2-bed admission units, two 6-bed crisis units, and two 20-bed acute treatment units at MSH. There will be two 24-bed new housing buildings for Transition Services, a library, chapel, store, café, a vocational center and a health care center.³⁴ These changes may change the dynamics on Units 800 and 900. However, improvements to physical setting without changes to policies and programming will likely do little to decrease the use of restraint and seclusion.

RECOMMENDATION 2: Ensure that the New Admissions Unit Adequately Meets the Needs of Newly Admitted Patients, Including Female Patients.

To reduce restraint and seclusion incidents, MSH should work to reform Unit 800 and 900. MSH has taken a positive step of creating a 4-bed admissions unit that will separate out new admissions from other high acuity, aggressive patients. Creating an evaluation and assessment unit that is appropriately staffed with mental health professionals will likely lead to a less chaotic environment, present an opportunity for more thorough evaluation and treatment planning, and reduce underlying escalators of behavior that lead to restraint and seclusion incidents. MDLC supports the creation of the new admissions unit, and believes it will help reduce the use of restraint and seclusion.

DHS should determine whether the new admissions units will be sufficient to serve all new admissions. Moreover, it is unclear to what extent the expanded admissions and crisis units will be equipped to house female patients. DHS should strive to provide female patients with the same opportunities to acclimate themselves to their new surroundings prior to mixing with the rest of the hospital population, and have crisis beds that are responsive to the treatment needs of women patients. These steps would likely help to reduce the use of restraint and seclusion.

FINDING 3. In practice, the use of restraint and seclusion does not uniformly conform to MSH's written policies and procedures, and in many cases represents substantial violations of these policies.

MDLC reviewed 103 restraint and seclusion incident files in order to gauge how the restraint and seclusion policy functioned in practice. This review of restraint and seclusion files revealed numerous incidents when restraint and seclusion appeared appropriate to prevent an imminent risk of harm. Specifically, staff members used restraint and seclusion to prevent assaultive behavior that presented a risk of imminent physical harm to other patients or staff.

Nevertheless, MDLC's review also found a significant number of incidents where the restraint and seclusion policy was misapplied or ignored. Specifically, MDLC identified multiple instances where staff failed to identify antecedent behavior or attempt to apply least restrictive

³³ See In the Matter Involving Mediation Related to the Minnesota Security Hospital, Abatement Plan at 13 (Aug. 4, 2014) [Hereinafter "OAH Abatement Plan."] available at <http://www.house.leg.state.mn.us/comm/docs/74c3376f-89dc-47f6-bbd8-56cb78fe21c8.pdf>.

³⁴ *Id.* at 16.

methods, used restraint and seclusion when it was not necessary to protect a patient or other person from imminent risk of harm, and did not follow appropriate release criteria.

- **Staff failed to acknowledge and document antecedent behaviors and belatedly attempted less restrictive measures, resulting in failure to prevent restraint and seclusion.**

The MSH restraint and seclusion policy requires staff to consider “least restrictive interventions” before using restraint and seclusion.³⁵ Staff are required to document these supportive interventions, and must refer to a patient’s treatment and support plans for supportive interventions that are tailored to the patient’s individual needs. Despite these requirements, MDLC found that there was not a coordinated effort by staff to identify and understand behaviors and triggers known to result in increased agitation. MDLC also found that supportive interventions and de-escalation techniques were often not implemented in a timely manner, and were attempted only when the patient was already very agitated.

MSH staff frequently could not identify any antecedent behaviors that lead to the use of restraint and seclusion. Out of the 103 files that MDLC reviewed, 96 contained a “Restraint and Seclusion Intervention Data Form,” which has a space to note any prior events that contributed to the restraint and seclusion. Thirty-three out of the 96 forms, or 34%, did not identify any prior events, and stated that use of restraint that the behavior that triggered the incident was “unprovoked” or “unknown.”

For example, on March 22, 2013, a patient was restrained and secluded on Unit 800 after he physically attacked a doctor who told him that his medication would be increased. Staff described the assault as “impulsive” and “unpredictable.” However, two months earlier on January 7, 2013, staff on Unit 700 restrained and secluded the same patient when he attacked staff after being informed that his medication would be increased. The records from the March 22 incident make no reference to the January 7 incident. It does not appear that staff at any point identified “increasing medication” as a possible trigger for this patient.

Furthermore, the most common supportive interventions documented by staff were “negotiation” and “redirection.” However, a detailed review of restraint and seclusion records reveals that the only “negotiation” and “redirection” that occurred in many instances was that staff told the patient to stop a particular behavior. Individual treatment support plans were rarely mentioned in the Restraint and Seclusion Intervention Data Forms that are used to track restraint and seclusion incidents. In sum, it appears that least restrictive interventions were often not timely considered prior to the use of restraint and seclusion.

Patients interviewed by MDLC also pointed to the lack of a structure for conflict resolution as a problem that contributes to the use of restraint and seclusion. Patients identified not having a safe, structured way to address issues they have with another patient, or with staff, as a source of frustration and sometimes agitation if left unaddressed. Patients expressed to MDLC that they live in a situation where they do not have any power; as a result, they feel that they cannot safely

³⁵ MSH RESTRAINT AND SECLUSION POLICY, *supra* note 20, at 3.

speak up or that, if they do, their concern is not addressed in a structured process leading to genuine resolution.

- **Use of restraint and seclusion occurred where there was not a risk of imminent harm.**

The MSH Restraint and Seclusion policy clearly states that restraint and seclusion should only be employed to prevent the risk of imminent harm. It is well established that restraint and seclusion should not be used as punishment and should never be considered a therapeutic option. Nevertheless, MDLC's review of restraint and seclusion records identified multiple instances where restraint and seclusion appeared to be used as punishment for bad behavior, and in some cases as part of a treatment plan.

For example, on December 12, 2012, a patient was documented in the record as "refusing to follow staff redirection all day." The patient was verbally abusive and swearing at staff. At around 2:00 PM, the patient was asked to go to his/her room because s/he was causing a disruption on the unit. After initially refusing, the patient got up, knocked over a table and garbage can, but then walked to his/her room on his own. After the patient entered his/her room voluntarily, staff secluded the patient by locking him/her in his own room for the next six hours.³⁶ Although the patient behavior may have been disruptive, it is unclear in the records why seclusion was deemed necessary to protect the patient or others from imminent risk of harm. On the contrary, the use of seclusion after the patient had calmed down appeared to be a punishment for the patient's vulgar language directed toward staff.

For another patient, MSH staff drafted a treatment plan that called for the patient to be secluded if he/she failed to follow staff directives. This treatment plan led to incidents like one that occurred on April 25, 2013. On that day, the patient took his/her breakfast into his/her room in violation of the unit policy. Staff approached the patient and informed him/her that he could not keep food in his/her room. After initially refusing, the patient gave his/her food to the staff member, yelled profanity at the staff, and told them to leave his/her room.

At this juncture, it appears from the written records that no threat of imminent harm existed. However, staff believed that the patient "violated" his/her support plan and thus needed to be secluded. Consequently, staff entered the patient's room, physically removed him/her, and placed him/her in seclusion for an hour. In this instance, it appears clear that seclusion was used to punish the patient for his/her refusal to follow staff direction. This does not comport with the definition of imminent risk of harm, and violated MSH policy. Rather, this use of physical restraint and seclusion is more akin to a correctional model, where patients are placed in administrative segregation as punishment for bad behavior.

In a number of instances, restraint or seclusion took place where it appeared that the risk of imminent harm had dissipated. For example, in February 2014, a patient attempted to strike another patient and then walked into a dining area. The patient then sat down and refused to

³⁶ This action also violated the MSH policy of prohibiting seclusion in a room that does not have a toilet. The restraint and seclusion documentation notes that the sink in his room is available for "hygiene/elimination."

move. After a few minutes of negotiation with staff, the patient agreed to walk to the restraint chair, where s/he remained for approximately two hours. Having regained composure to the point of walking to a restraint chair of the patient's own accord, and negotiating with staff, it is highly questionable that the patient still presented a risk of imminent harm such that restraint was needed.

- **Release criteria or release process did not follow policy.**

In other incidents, while the initial restraint and seclusion appeared appropriate, the length of the restraint and seclusion incidents extended well beyond what appeared necessary. Release criteria established was ignored in many cases. Moreover, staff often did not adequately document release criteria.

For example, on January 25, 2013, a patient was manually restrained at 9:11 PM, placed in handcuffs at 9:17 PM, and placed in seclusion at 9:21 PM for starting a fight with another patient. The patient's release criteria stated that s/ he needed to "demonstrate calm and controlled behavior, contract for safety, and discuss events leading to aggressive behaviors." At 11:00 PM, the patient met with a psychiatrist, and was described in progress notes as "calm" and "cooperative." Nevertheless, the patient was not released from seclusion until 12:34 AM. Documentation in the patient's record did not provide any legally acceptable basis for continuing the use of seclusion.

On June 18, 2013, a patient was manually restrained at 1:50 PM because s/he was spitting at and threatening staff members. The patient was placed in the restraint chair at 2:05 PM. The release criteria included "calm controlled behavior" and being "able to contract for safety of self and others." At 3:15 PM, the patient observation notes stated that the patient had his/her "eyes closed as if appearing to be sleeping" and that s/he informed staff that s/he "would contract for safety." Nevertheless, the patient was not released from the restraint chair until 4:25 PM. Again, it appears that the patient no longer presented a threat of imminent harm to himself/herself or others well before s/he was actually released from the restraint chair.

These instances demonstrate that significant progress in implementation of best practices, designed to ensure that restraint and seclusion occur only when absolutely necessary, and be used for the shortest time required, still need to be made.

RECOMMENDATION 3: Despite substantial efforts to eliminate the use of restraint and seclusion in all incidents that do not present a risk of imminent harm, additional efforts should be made to ensure that the policy is clearly understood, implemented and enforced. In addition to basic training on the policy, unit supervisors and clinical staff serving each unit should ensure that every staff person working with patients is competent in its implementation. As part of this effort, staff should be required to become familiar with the treatment and behavior plans for every patient that they work with, even if staff are not on their regularly assigned unit, or if the patient is someone unfamiliar to them.

FINDING 4: While the Current Restraint and Seclusion Policy Conforms to Basic Legal Standards, It Does Not Comply with DHS’s New Positive Support Strategies Rules.

DHS has publicly recognized that the use of restraint and seclusion is an abusive practice. DHS has stated that it will “prohibit procedures that cause pain, whether physical, emotional or psychological, and establish a plan to prohibit use of seclusion and restraints for programs and services licensed or certified by the department.”³⁷ DHS has committed itself to not only “follow legal and regulatory requirements limiting the use of seclusion and restraint,” but to create a “broader culture that honors the trust placed in [DHS] both as a provider and as a department responsible for the administration and oversight of many of the services that support citizens.”³⁸

In light of these statements, DHS has developed a restraint and seclusion policy at MSH that conforms to basic legal and treatment standards limiting the use of restraint and seclusion to circumstances where it is clear that there is an imminent risk of harm for the patient or others. However, the current policy does not comply with DHS’s own proposed positive support strategies rules that will become law in Minnesota in the near future. The lawsuit and subsequent settlement agreement in *Jensen v. Minnesota Department of Human Services* require Minnesota to reform its rules governing “aversive procedures,” including restraint and seclusion. A legislative mandate requires the Commissioner of DHS to adopt rules to eliminate the use of restraint and seclusion for programmatic purposes in “all licensed facilities and licensed services serving persons with developmental disabilities” by August 31, 2015.³⁹ MSH is currently licensed under Minnesota Statutes, chapter 245A, and therefore will need to comply with the rules when serving patients with developmental disabilities.

To comply with this mandate, DHS proposed new rules governing positive support strategies and the use of aversive procedures such as restraint and seclusion. These rules prohibit the use of all forms of restraint and seclusion, with the limited exception for the emergency use of manual restraint in situations to prevent imminent risk of physical harm. The proposed rules also require providers to implement positive support strategies and person-centered principals when providing care. The proposed rules were approved by an administrative law judge on April 22, 2015, and should go into effect by August 31, 2015.

In order to conform to the new rules, MSH would need to substantially revise the current restraint and seclusion policy. Specifically, the MSH policy allows for mechanical restraints, including the restraint chair, as well as seclusion in situations where there is an imminent risk of harm. However, the proposed rules only allow for the use of emergency manual restraint in these instances. In addition, the proposed rules prohibit the use of token and level programs, as well as “negative punishment.” Token and level programs, as well as “negative punishment,” are key components of MSH’s current treatment program.

³⁷ See RULE 40 ADVISORY COMM., RULE 40 ADVISORY COMMITTEE RECOMMENDATION ON BEST PRACTICES AND MODERNIZATION OF RULE 40 (July 2, 2013), available at http://mn.gov/mnddc/meto_settlement/documents/Rule-40-Final-7-2-13.pdf.

³⁸ *Respect and Dignity Practices Statement*, supra note 10.

³⁹ MINN. STAT. § 245.8251, subd. 1 (2014).

DHS management has indicated in conversation with MDLC that MSH does not plan to apply the new positive support strategies rules to all MSH patients. Rather, DHS intends to have two separate policies governing restraint and seclusion (and presumably treatment programming) in effect: one for patients with developmental disabilities, and one for patients without developmental disabilities.⁴⁰

RECOMMENDATION 4: DHS should ensure that a uniform policy governing the use of restraint and seclusion, and the application of positive treatment interventions according to the new behavior rule, apply to all patients at MSH.

Adopting two different policies for restraint and seclusion based on a patient's disability will create both practical and philosophical problems. As a practical matter, patients who have been committed to MSH as Mentally Ill and Dangerous may also be diagnosed with a developmental disability. Although Unit 200 is specifically designed for patients with developmental disabilities, there are other patients with developmental disabilities housed in various units throughout the hospital. Consequently, all staff will be required to know which policy applies to which patients. In addition, some patients would have an expressed right to the use of positive support strategies in their individual treatment plans, a right which other patients would not specifically have.

The proposed positive support strategies rule will outlaw the use of the restraint chair for individuals with developmental disabilities at MSH and other programs licensed by DHS because it is considered an abusive practice for these individuals. The use of the restraint chair for individuals with mental illness, which will still be permitted at MSH, is no less abusive and traumatic. DHS should ensure that there is a uniform restraint and seclusion policy for all patients at MSH.

FINDING 5: Conflict management and resolution processes, which were recommended by some patients during interviews and which have been shown to be effective in reducing violence and frustration in mental health settings, are largely absent from MSH.

Based on the information gathered in MDLC's investigation, there does not appear to be any formal conflict or dispute resolution tool in place at MSH. When MDLC interviewed patients for this report, more than one patient suggested that the use of conflict or dispute resolution processes would reduce interpersonal conflicts and assaults among patients, and would moderate disagreements between patients and staff.

During patient interviews, patients expressed continuing frustration and concerns for their own safety. Recent patient assault data from MSH supports these concerns. Patient-to-patient assaults without injury consistently were between 10 and 15 a month during the winter months of 2014 and 2015. Overall, assaults dropped into the single digits during the summer months when patients had more opportunities to go outside, except in July 2014.⁴¹ Patient satisfaction surveys also illustrate continuing patient concerns about their own safety. In 2011, just over 55% of

⁴⁰ MDLC Conversation, *supra* note 30.

⁴¹ Forensic Services, Data Provided to MDLC: Patient to Patient assaults—with and without injuries (Apr. 2015).

patients at MSH agreed with the statement “I feel safe here.” This percentage went up to about 79% in 2013, but dropped to 70% in 2014.⁴²

Patients also pointed out that a dispute resolution process could help address their concern that complaints are not listened to and addressed by staff, which also leads to frustration and sometimes violence. This concern appears to be borne out in MSH data reflecting that the least improvement in patient satisfaction has occurred in the area of addressing patient complaints.⁴³

The National Association of State Mental Health Program Directors (NASMHPD) issued a report which supports the use of conflict management and dispute resolution in mental health inpatient settings.⁴⁴ The report encourages conflict management programs as “a natural fit in the mental health field” for a number of reasons. It is a model consistent with principles of recovery, because it focuses on the “restoration to individuals of a sense of their own value and strength and their own capacity to handle life’s problems.”⁴⁵ It is also “effective in complex crisis situations” because it is “a psychologically informed process designed to improve communication” which facilitates dialogue in polarized groups. Those trained in conflict management can be particularly effective in handling the high level of emotion often present in mental health disputes.”⁴⁶ As an example, Arizona State Hospital has a long-running inpatient mediation program which “has successfully resolved a wide variety of complaints, grievance and conflicts, including disagreements over medications.”⁴⁷

RECOMMENDATION 5. MSH should promote conflict management and dispute resolution tools which patients and staff can use to resolve disagreements in a mutually respectful way, leading to a reduction in potentially assaultive situations and corresponding use of restraint and seclusion. MSH should strongly consider a model of conflict management and dispute resolution for a range of disagreements or incidents between patients, and between patients and staff. Use of effective conflict resolution can result in fewer incidents of patient-on-patient aggression, reduce the likelihood of situations leading to imminent harm, and promote mental health recovery.

⁴² DHS Dashboard 2015 SOFS Safety and Environment Rate.

⁴³ 2014 ANNUAL REPORT, *supra* note 27, at 37.

⁴⁴ ANDREA BLANCH & LAURA PRESCOTT, NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRS. & NAT’L TECHNICAL ASSISTANCE CTR. FOR STATE MENTAL HEALTH PLANNING, MANAGING CONFLICT COOPERATIVELY: MAKING A COMMITMENT TO NONVIOLENCE AND RECOVERY IN MENTAL HEALTH SETTINGS(Dec. 2002), *available at* <http://www.nasmhpd.org/sites/default/files/ManagingConflictCooperativelyADR%281%29.pdf>.

⁴⁵ *Id.* at 5.

⁴⁶ *Id.* at 7.

⁴⁷ *Id.* at 11.

B. MSH Fails to Provide Proper Debriefing and Adjustment of Behavior Plans in Response to the Use of Restraint and Seclusion.

FINDING 6: The restraint and seclusion debriefing process lacks effective analysis and responses that will lead to a reduction in future restraint and seclusion incidents.

The use of restraint and seclusion is a traumatic process that can negatively impact the physical and mental well-being of patients and staff.⁴⁸ Growing evidence supports a link between a history of trauma and seclusion. For instance, one recent study at Missouri's Fulton State Hospital found that 70% of a class of patients experiencing the most frequent seclusions and restraints had histories of childhood abuse.⁴⁹

In recognition of this concern, the MSH restraint and seclusion policy includes a "debriefing session" where the patient and available staff discuss the incident. The debriefing process, which appropriately occurs within 24 hours of the episode, is conducted by the assigned RN. However, the policy does not require the RN to have any additional expertise in the behavioral aspects of treatment planning. According to the MSH restraint and seclusion policy, the debriefing process will:

- a. attempt to re-establish a therapeutic alliance with the patient;
- b. identify what led to the incident and what could have been handled differently;
- c. determine that the patient's physical well-being, psychological comfort and right to privacy were addressed;
- d. counsel the patient involved for any trauma that may have resulted from the incident; and
- e. make recommendations to modify the patient's treatment plan to the designated treatment plan author.

In a recent change, if the patient chooses not to participate in the debriefing, a staff acts as an intermediary, attempts to meet with the patient, brings the patient's experiences back to the team, and brings recommended changes by the team back to the patient.⁵⁰

Many of the restraint and seclusion incidents that MDLC reviewed did not contain a meaningful review or debriefing process. Consequently, individual patients experienced multiple incidents of restraint and seclusion, with minimal efforts to adjust treatment plans in order to prevent future imminent risk of harm. Out of the 103 incidents that MDLC reviewed, 95 included the "Restraint and Seclusion Debriefing Form." On the debriefing form, staff are asked to examine what different steps they could take "next time" to prevent the future use of restraint and seclusion. On 41 of the 95 forms, or 43 %, staff did not identify any steps that would lead to an outcome where restraint and seclusion are not used. Rather, the blame for restraint and seclusion

⁴⁸ See Lori Aschraft & William Anthony, *Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services*, 59 PSYCHIATRIC SERVICES 1198 (Oct. 2008) (citing various scientific studies documenting the traumatic effect of restraint and seclusion).

⁴⁹ Hammer et al., *The Relationship between Seclusion and Restraint Use and Childhood Abuse Among Psychiatric Patients*, 26 JOURNAL OF INTERPERSONAL VIOLENCE 567 (Feb. 2011).

⁵⁰ MSH RESTRAINT AND SECLUSION POLICY, *supra* note 20, at 4.

incidents was placed on the patient as a matter of course. For example, in one instance, a staff member wrote that to prevent use of restraint, the “patient could have listened to staff directives.”

Furthermore, changes to treatment plans were rarely made following a restraint and seclusion incident. On the debriefing form, staff are asked to recommend changes to the patient’s treatment plan to prevent the use of restraint and seclusion. On 48 out of 93⁵¹ forms, or 52%, staff did not recommend any type of change to the treatment plan. In other instances, staff wrote “update treatment plan,” without any further details on how to follow up. When changes were recommended, the most common suggestions were to increase medication, increase continuous observation, or begin Electroconvulsive Therapy (ECT). In one instance, staff suggested changing a patient treatment plan to permit the use of prone restraint. This suggestion contradicted the patient’s individual abuse prevention plan, which specifically stated that prone restraint should not be used.

In most instances, patients did not contribute to the debriefing process. The standard debriefing form did not contain a space for patient input prior to 2014. As a result, only 18 incidents that MDLC reviewed used the debriefing form that had a space for patient input. Sixteen out of those 18 forms, or 88%, did not contain any input from the patient.⁵² In many of these instances, patients were not allowed to participate in the debriefing process because it was determined to be “counter-therapeutic.”

An example of a completed debriefing from April 2014 highlights many of these characteristics. A patient became upset when s/he was unable to make phone calls because the phone line was not working properly. The patient tore his/her socks, tied them around his/her wrist, stood on a shelf, and failed to respond to staff. The patient was placed in manual restraints and then the restraint chair for an hour and ten minutes.

The debriefing “session” occurred 30 minutes after the patient was released from the restraint chair. The patient was not included in the debriefing session because it was “counter-therapeutic.” In response to the question of what could be done differently, staff stated that the patient was “reluctant to listen to staff’s least restrictive interventions” and “failed to use his/her own coping skills as defined in her treatment plan.” In response to the question of what supports were offered to the patient, staff wrote that the “patient was informed that as the result of his/her actions, that s/he would be placed in the restraint chair until s/he could contract for safety.” For recommendations to the treatment plan, individual abuse prevention plan, or support plan, staff wrote “none.” Perhaps not surprisingly, the same patient was restrained again later on in the evening and then again the next day.

This example is consistent with findings of the review of 22 incidents by DHS Licensing in February 2014. That review found that in 22 of 22 required debriefing reviews by staff, the question of “What could have been done differently by staff or the Vulnerable Adult (VA)?” did not include any ideas of what the staff could have done differently. Sixteen of the reviews

⁵¹ Two of the debriefing forms did not contain the page where the “Recommended Changes to Treatment Plan” question is found.

⁵² MDLC acknowledges that the majority of these incidents involved a single patient.

focused only on the VA and stated that “the VA should have used coping skills” or “the VA should not have engaged in self-injurious behavior” and “the VA was given many opportunities.” Six debriefing sessions did not include the VA because the team deemed it “un-therapeutic” or “counter-therapeutic” to include the VA in debriefing. Twelve sessions did not document why the VA was not included. Of particular note, in reviewing recommendations for changes to the treatment plan, eight times the recommendation was to initiate ECT on the VA. Other treatment plan recommendations included “PRN,” “more concrete rules and boundaries” and “the VA should use coping skills.”⁵³

Counseling for trauma resulting from the incident is currently part of the debriefing policy, yet there is no requirement that this counseling be safely done in private, or out of the presence of the staff involved in the incident. Additionally, there is no requirement that trauma counseling be done by someone trained in trauma therapy, particularly individual therapy. MDLC’s review of patient records revealed that little, if any, trauma counseling had occurred during or after the debriefing process. This is an important concern because of the link between repeated restraints and childhood abuse:

“Once safety has been assured, it is critical to unravel the present and past roots of the conflict. In mental health, this almost always involves understanding the role of trauma. The relationship between physical and sexual abuse and severe mental health and substance abuse problems has now been extremely well documented...A clear and unbiased focus on trauma can be extremely helpful in efforts to reduce conflict and violence in all mental health treatment settings, including state hospital cultures.”⁵⁴

RECOMMENDATION 6: To be effective, the debriefing process should require analysis of what the staff should have done better, including whether they have accurately identified supportive and least restrictive interventions and have timely implemented them.

The debriefing requirement does not specify whether “what led to the incident and what could have been handled differently” applies only to the patient, or equally to the staff involved in the incident. MDLC review of records showed that in the debriefing process, staff primarily focuses on patient behavior and choices. The debriefing does not require a review of the staff’s use of required supportive interventions as mandated in the restraint and seclusion policy, address whether least restrictive interventions were appropriately and timely utilized by staff, or if these interventions were appropriately identified to begin with. In order for the debriefing process to be meaningful, these items should be part of the analysis and should be continuously tracked and reported on by MSH.

⁵³ DIVISION OF LICENSING, MINN. DEP’T HUM. SERVICES, DHS LICENSING DETERMINATION OF MALTREATMENT, LICENSING REPORTS 20141080 (Oct. 28, 2014).

⁵⁴ BLANCH & PRESCOTT, *supra* note 44, at 8 (citing Lyndra Bills & Sandra Bloom, *From Chaos to Sanctuary: Trauma-Based Treatment for Women in a State Hospital*, in WOMEN’S MENTAL HEALTH SERVICES: A PUBLIC HEALTH PERSPECTIVE 348 (Bruce Levin et al. eds., 1998)).

RECOMMENDATION 7: To be effective, a debriefing process should be done at a time when the patient is able to participate in the process, and staff with experience in behavioral analysis who were not involved in the incident should participate. Trauma counseling should be a separate process.

As noted above, the debriefing process at MSH frequently excludes patient participation because it would be ‘counter-therapeutic.’ Thus, the patient is not meaningfully involved in figuring out what caused the incident and what changes would make a difference. Even where the patient is included, there is not an even playing field. Having just been placed in restraints or seclusion, it can be very difficult for the patient to respond honestly to the question “what could have been done differently?” The debriefing also puts the patient in the midst of a group of staff who seek to justify their decision to seclude or restrain. A peer specialist or outside individual should be included in the process to lower the intimidation factor and provide support for the patient.

Additionally, staff with professional expertise in behavior analysis and program planning should be part of the debriefing process, in particular to positively address what could and should be done differently by staff. It may also be in the patient’s interest to have that expertise represented by a professional who is not part of the unit’s treatment team, and not conflicted by having to work with that group of people on a daily basis.

Lastly, trauma counseling should be done in private by persons trained in trauma therapy, and not as part of the debriefing process unless this is requested by the patient.

RECOMMENDATION 8: MSH’s policy should be modified to ensure that quality follow up and accountability, including changes in treatment, flow from the debriefing process.

The debriefing process requires those doing the debriefing to make recommendations to modify the treatment plan. However, the policy does not require follow up to document how often recommendations are made; a review of whether the recommendations are clinically sound; whether recommendations have been accepted into the plan and implemented; and whether the recommendations are successful once implemented.

The treatment team should track changes in treatment, including whether the change has been effective in reducing seclusion or restraint. If the change was not effective, the team should look at what steps will be taken next and who will be responsible for implementation. All of this should be documented in the patient’s chart. Ongoing accountability is key to preventing future incidents of restraint and seclusion.

FINDING 7. Behavior management reviews and clinical reviews are not patient-centered, are often ineffective, and frequently do not result in positive changes to a treatment plan that will lead to a reduction in restraint and seclusion use.

When a patient experiences frequent use of seclusion and restraint, MSH staff will often develop “behavior management plans.” The treatment team is responsible for development,

implementation, monitoring and modification of all behavior management plans. A behavior management plan is part of the individual treatment plan and uses both positive and restrictive procedures to change a behavior or develop adaptive skills.⁵⁵

The Behavior Management Plan policy requires that the team seek input from the patient, and that the plan must be written in a manner understandable to the patient. The team will attempt to obtain the patient or the guardian or conservator's consent before submitting the plan to the Behavior Management Review Committee (BMRC).⁵⁶ If the patient does not consent, the patient advocate is asked to consent. If the patient, guardian or conservator wants a particular plan and the team is not in agreement, the team "may" but is not required to submit the plan to the BMRC for review.

The BMRC is responsible for approving and reviewing all behavior plans and ensuring the plans meet appropriate standards. If the team does not agree with the BMRC decision, the team may appeal to the forensic medical director. The BMRC chair and a team member will meet with the medical director, and the patient advocate is invited.

The BMRC is also responsible for monitoring and tracking trends and instances of restraint and seclusion, with particular attention to frequent use within a twelve hour period, and three or more incidents in a month. The BMRC can recommend changes to individual treatment plans which the team is required to implement within a week. The policy does not require patient involvement in this process. It does not appear from the policy that the data from monitoring and tracking the patient is shared with the patient.

This process is not patient-centered. The patient does not have the right to propose a plan to the BMRC, or to appeal a BMRC decision to the forensic medical director. In addition, because this is an internal process, there is no option for the patient to request "fresh eyes" – a knowledgeable outside expert who can review a behavior management plan and propose appropriate adaptations.

Besides the BMRC, there is a Clinical Consultation Committee (CCC)⁵⁷ which is also charged with providing consultation on behavioral and treatment issues, in particular in identifying relevant treatment interventions including behavioral and pharmacologic interventions. This appears to duplicate some of the roles and responsibilities of the BMRC, while including other aspects of treatment such as medication and ECT. MDLC's review of patient records for persons frequently restrained or secluded did not find any records documenting consultation by the CCC, or reference to a CCC review. It would appear that the CCC is rarely used for patients with a history of being frequently restrained and secluded.

⁵⁵ STATE OPERATED FORENSIC SERVICES, MINNESOTA DEPARTMENT OF HUMAN SERVICES, BEHAVIOR MANAGEMENT PLANS, PROCEDURE NUMBER 6310 (July 24, 2013).

⁵⁶ It is unclear why the conservator is included in this process. Generally, conservators do not have the authority to make medical decisions on behalf of a conservatee. If a patient has a conservator but not a guardian, unless the court has taken an unusual step of giving the conservator the authority to make medical decisions, these decisions remain with the patient.

⁵⁷ STATE OPERATED FORENSIC SERVICES, MINNESOTA DEPARTMENT OF HUMAN SERVICES, PROCEDURE NUMBER 10003 (Feb. 10, 2012).

Unfortunately, as with the BMRC, the patient does not have an opportunity for direct access to the CCC. It is also not clear why a BMRC review of behavior plans is partitioned from a CCC review of overall treatment, and why two review processes are needed. During interviews with the MDLC, no patient identified the BMRC or CCC as meaningful or helpful to reducing the use of restraint and seclusion.

RECOMMENDATION 9: Create better review committee accountability. DHS should ensure that the review committees evaluate the effectiveness of the treatment team's implementation of their recommendations on a regular basis for each patient who is the subject of a review. The review committees should be required to keep and analyze data on the success or failure of its recommendations, individually and for each MSH unit, on a regular basis. If the review committee recommendations do not result in positive changes, the review committee should be charged with the task of arranging consultation with outside professionals who have expertise in the problem area, and for ensuring the appropriate implementation of any recommendations.

RECOMMENDATION 10: Allow patients to make treatment plan proposals to the BMRC and CCC and to appeal decisions regarding their treatment. In a person-centered philosophy of treatment, there should be the opportunity for the patient to propose a plan to the BMRC and to appeal a BMRC decision to the forensic medical director. This is particularly important where there have been repeated instances of restraint or seclusion. Patients should also be able to request and receive consultation by outside mental health professionals with expertise in positive behavioral approaches that have not been tried in the patient's treatment program. In addition, data collected and analyzed by the review committee should be shared and discussed with the patient who is the subject of the review. Similar provisions should apply to the CCC process.

C. Staff Training in Effectively Preventing the Need for Seclusion and Restraint Should Be Enriched.

FINDING 8: While improvements have been made in staff training, there is not a robust plan to provide ongoing training, involving both patients and staff, that will lead to a permanent reduction in the use of restraint and seclusion.

MDLC reviewed a relatively small sample of restraint and seclusion incidents at MSH, and most of these incidents occurred before the implementation of person-centered treatment training for all hospital staff. However, MDLC's review found significant discrepancies between the written policies and procedures governing restraint and seclusion, and implementation of these policies. In the last two years, DHS has increased the amount of training required of MSH staff. All MSH staff, regardless of whether they are maintenance workers or psychiatrists, have now been trained in person centered thinking. Training on the use of restraint and seclusion now occurs every twelve months. DHS has also instituted additional training for coaches on each unit, in part to improve the treatment team's responses to individuals who are having difficulty controlling their behaviors. These improvements in training are very important, but not yet sufficient to ensure changes in staff behavior.⁵⁸

⁵⁸ For example, a recent DHS licensing investigation report substantiated maltreatment by a staff person who repeatedly told a patient that the patient was "acting like a big f*****g baby," "triggering" the patient's behavior.

In order to permanently reduce the use of restraint and seclusion, robust and intensive staff training is crucial. Staff should have a firm grasp of not only the restraint and seclusion policy, but also the person-centered, positive support practices that should be implemented in lieu of aversive procedures. Despite substantial efforts to eliminate the use of restraint and seclusion in all incidents that do not present a risk of imminent harm, additional efforts should be made to ensure that these policies and their underlying philosophy are clearly understood, implemented and embraced by all.

Understanding behaviors leading up to assaults is crucial, as is the knowledge needed to address those behaviors in a positive way. For example, debriefing should not be a rote exercise done because the policy requires it. It should be another opportunity for knowledgeable staff to analyze behavior, and in concert with the patient, make positive adjustments to treatment programs. Staff thus gain appreciation and mastery of those skills needed to weave positive approaches into every day interactions. Use of best practices and sound training on prevention of future incidents delivers the message from management to staff that if treatment is working, restraint and seclusion will almost never need to be used.

Lack of adequate documentation in patient records also continues to be a problem. In a recent investigation of maltreatment related to the use of restraints, the failure of the unit staff to adequately document incidents directly resulted in DHS Licensing's inability to determine whether maltreatment had occurred.⁵⁹ This failure to adequately document restraint incidents should not be justified by a finding of "inconclusive," as happened in that investigation. The failure to adequately document patient care or lack thereof, and the subsequent failure of MSH to identify this failure as a problem and to address it, is itself a violation of MSH policy and licensing requirements. Training on incident reporting is required once, and it is not known to what extent this training addresses adequacy of documentation.

Frequency of training is also an issue. While all staff have been trained in person-centered thinking, according to the MSH annual reports, the frequency of required training on person centered thinking is "once." Trainings on "trauma informed care," "imminent risk and patient safety," and "Risk, Assessment, Treatment," are also required once. In contrast, "blood glucose monitoring and insulin," "safe medical sharps management" and "Putting security into action" occur every 12 months.⁶⁰

Thorough training on the appropriate use of restraint and seclusion can reduce both the need for restraint and seclusion and the likelihood of staff and patient injuries. This principle is supported by ample evidence. Significant reductions are being reported by many institutions as a result of systemic restraint and seclusion training programs, in particular NASMHPD's "Six Core Strategies" curriculum. Recent examples of facilities that have experienced positive results as a result of training include:

- Johns Hopkins Hospital reduced restraint and seclusion use by 75 percent with no increase in staff or consumer injuries (Lewis, Taylor, & Parks, 2009);

See DIV. OF LICENSING, MINN. DEP'T HUM. SERVICES, INVESTIGATIVE MEMORANDUM #20150652 (Apr. 8, 2015). Presumably this staff person had received the person-centered training provided to all MSH staff.

⁵⁹ DIVISION OF LICENSING, MINN. DEP'T HUM. SERVICES, DHS LICENSING DETERMINATION OF MALTREATMENT, LICENSING REPORTS 20141080 8 (Oct. 28, 2014).

⁶⁰ 2014 ANNUAL REPORT, *supra* note 27, at 7.

- Florida State Hospital at Chattahoochee, Florida reduced its use by 54 percent and realized nearly \$2.9 million in cost savings from reduced worker's compensation, staff and consumer injuries, and length of stay costs. (Florida Tax Watch, 2008);
- Taunton and Westboro State Hospitals in Massachusetts reduced restraint and seclusion use more than 90 percent following NASMHPD training and SAMHSA incentive grant participation. (Huckshorn, Caldwell, & LeBel, 2008).⁶¹

In contrast to this evidence, data reported by DHS concludes that seclusion and restraint are down, but staff injuries are up. An explanation for this result has yet to be offered. However, MDLC believes that attempts to reduce seclusion and restraint usage – and injuries – will fail if staff at MSH do not understand the reasons for what they are doing, and if better efforts at behavior analysis and creation of positive alternatives are absent from their treatment of patients.

One training approach also found to be effective in other facilities as part of patient treatment is a restraint prevention plan, developed by staff and patient, that the staff and patient practice together. Development of the plan involves patient and staff review of the patient's trauma history, anger triggers, medical risks, what works when one is angry but can still listen, and what works when one is angry and cannot listen. After the plan is developed, the patient and staff then practice the plan, including role playing, modifying as needed to make sure the plan works and enabling all concerned parties to know what to do when a crisis is brewing.⁶² A restraint prevention plan can work especially well for patients who face frequent use of restraints or seclusion.

RECOMMENDATION 11: Intensive, ongoing training with a goal of continuous improvement in all aspects of restraint and seclusion policy and practice is needed at MSH, including review of staff implementation of training programs by experienced professionals. MDLC supports the principle contained in the DHS Abatement Plan calling for more hands-on training of staff, including training in scenarios about risk of imminent harm.⁶³ However, training that enables staff to better recognize imminent harm is not sufficient. Unit staff also need ongoing, intensive training by mental health professionals who can help staff identify patient behaviors and how best to respond at critical junctures *before* restrictive interventions, de-escalation or restraint is called for. MSH should also consider restraint prevention plans that involve patients and staff, and include as a key element actually practicing the plan.

MSH should ensure adequate funding of quality, enriched training of staff. Given data reported by DHS that conclude that seclusion and restraint are down while staff injuries are up, MSH needs to have staff implementation of training reviewed by experienced professionals. A thorough review of training regarding direct patient care and therapeutic responses to patient

⁶¹ SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., THE BUSINESS CASE FOR PREVENTING AND REDUCING RESTRAINT AND SECLUSION USE 15 (2011).

⁶² See, e.g., Kim Masters, *How to Create and Evaluate a Seclusion and Restraint Prevention Plan*, AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY NEWS(May/June 2005) available at http://www.aacap.org/aacap/Member_Resources/Practice_Information/SR_Articles/How_to_Create_and_Evaluate_a_Seclusion_and_Restraint_Prevention_Plan.aspx (citing the NATIONAL EXECUTIVE TRAINING INSTITUTE TRAUMA INFORMED CARE RESOURCE MANUAL FOR THE REDUCTION OF SECLUSION AND RESTRAINT ch. 7 (2003)) (delineating elements for seclusion and restraint plans, including review and modification).

⁶³ OAH Abatement Plan, *supra* note 33, at 17.

aggression will result in more effective treatment that is the product of careful assessment, well-designed positive treatment plans, and efforts to make these plans understood by staff and patients.

RECOMMENDATION 12: MSH should gather more detailed data to track the effectiveness of its training, including what aspects need to be enhanced in order for it to be effective. To continuously move toward its goal of not using seclusion and restraint, MSH should train all staff working directly with patients on adequate and professional documentation of restraint and seclusion incidents and patient records. MSH should also make training in the reduction of seclusion and restraint a priority for all staff working with patients. This will require direct involvement of mental health professionals who have expertise in identifying problematic behaviors and working with patients on implementation of positive supports. In addition, MSH training efforts should include the enlistment of outside professionals to observe staff and make recommendations geared toward continuous improvement.

D. There is Insufficient Active Treatment Occurring at MSH to Address Individual Needs of Those Being Restrained and Secluded.

FINDING 9: The amount of active mental health treatment occurring at MSH is insufficient to meet the needs of high acuity patients who are frequently restrained and secluded.

In addition to evaluating the use of restraint and seclusion at MSH, MDLC sought to understand the reasons for the lack of a sustained and consistent reduction in overall use of these aversive procedures. Through patient interviews, review of patient files, and review of relevant literature, MDLC concluded that a lack of adequate active mental health treatment is a significant contributing factor to the ongoing use of restraint and seclusion.

Problems with adequate mental treatment at MSH are not new. In the 2013 Legislative Auditor report, one of the most disturbing findings was the very limited amount of active mental health treatment being provided. The Legislative Auditor looked at all weekly scheduled group and individual activities for 150 patients. On average, the patients had 16 hours of total scheduled activities per week, including jobs, education classes, recreation, wood shop, library, and social activities. Of that, the Legislative Auditor found that the average patient “had just over one hour per day of scheduled therapeutic activities,” which included counseling and psychoeducational activities, basic education courses and patient “community meetings.”⁶⁴ In comparison, the Legislative Auditor noted, the sex offender treatment program at MSOP averages at least 12 hours per week specifically devoted to treatment. The Legislative Auditor also raised concern about the limited contact between patients and psychiatry staff, noting that the majority of patients were seen less than monthly.⁶⁵

⁶⁴ 2013 OLA REPORT, *supra* note 15, at 107–08.

⁶⁵ *Id.*

The State Operated Forensic Services 2013 Annual Report indicated that “a work group is currently looking at the amount of treatment provided to individual patients at MSH to improve both the quality and quantity of treatment activities.”⁶⁶ MDLC could not find further reference to that work group in the 2014 Annual Report. However, in its December 2014 response to the Legislative Auditor’s concern about the adequacy of meaningful treatment, DHS stated it had changed its treatment policies to “more clearly define treatment” and to delineate what services fall under “therapeutic activities.”⁶⁷ While it may have expanded “treatment” and “therapeutic activities” to include more activities, DHS did not assert that hours of actual treatment have been increased. DHS Licensing unfortunately has not required any increases in actual therapeutic programming as part of the terms of the MSH conditional license.

In MDLC’s review of patient records and unit programming, there did not appear to be any noticeable increase in treatment programming since the 2013 Legislative Auditor’s report. The DHS policy entitled “Treatment Planning” does not set a minimum threshold for therapeutic treatment and does not set forth a range of treatment programming that is available to patients.⁶⁸ However, the policy’s definition of what is considered “treatment” is quite expansive. It identifies “treatment team” as the patient and “all individuals who provide supports or services to the patient.” Specific components of the individual treatment plan included “bio-psycho-social summary” of all assessments, current diagnosis, strengths and “learning issues;” individualized potential triggers; and individual treatment areas, including those to be addressed in the current quarter. “Treatment areas are derived from a “dynamic risk model” that includes such things as legal, physical, spiritual and cultural issues.”⁶⁹ In a number of cases, there was not a strong connection between the treatment received through the unit program and the individual’s treatment plan.

In order to better understand how the expansive Treatment Planning policy affects the ongoing use of restraint and seclusion at MSH, MDLC looked at clients’ treatment programming. Consequently, MDLC conducted an in-depth review of medical and treatment records for five patients. As part of this review, MDLC analyzed both unit and individual treatment programming.

- **Unit 800’s treatment programming occurs primarily on the unit in groups.**

Most MSH programming and treatment received by patients occurs in groups and on the patient’s unit. For example, the Unit 800 Fall Quarter 2014 hourly schedule for Tuesdays is as follows: team meetings/quarterly reviews; canteen; library; anger management; and gardening/coping skills. Anger management class occurs one hour per week, and is run by a Behavior Analyst. It focuses on how to distinguish between emotion and behavior, identify anger triggers, identify and recognize personal warning signs, identify strategies to interrupt impulsive responses, learn constructive ways to express anger, and learn and practice problem-solving skills.

⁶⁶ STATE OPERATED FORENSIC SERVS., FISCAL YEAR 2013 ANNUAL REPORT 35 (2013).

⁶⁷ OFFICE OF THE LEGISLATIVE AUDITOR, PROGRESS TRACKING FOR STATE OPERATED SERVICES 8 (Dec. 4, 2014).

⁶⁸ STATE OPERATED FORENSIC SERVICES, MINNESOTA DEPARTMENT OF HUMAN SERVICES, TREATMENT PLANNING, PROCEDURE NUMBER 10005/52150 (JUNE 9, 2014).

⁶⁹ *Id.* at 2.

Thursdays on 800 have the most mental illness related treatment. There is a 45-minute mental health education group run by a psychologist, who also runs a weekly one hour Dialectical Behavior Therapy group on that day. In addition, there is a second hour of the gardening/coping skills group on Thursdays.

The other therapy-related groups, all for one hour per week, are stress management; “New Outlook,” which explores anti-social attitudes and thinking errors; “Foundations,” which introduces the concept of recovery and identifies personal short and long term goals; and “Illness Management and Recovery.” There is also a movie group, which is a “mental health group focusing on symptoms and life experiences.”

There are eight hours of therapeutic programming per week; if gardening/coping skills is considered therapy, the total rises to 10 per week. Adding in the once weekly “creative expression” group and “relaxation group” brings the total that could possibly be considered related to mental health to 12 hours.⁷⁰ Other activities include canteen, library, recreation and vocational/educational activities. Some patients have jobs for several hours per week. “Canteen” as an activity accounts for 2.5 hours per day of the unit’s schedule. Except for “canteen,” no treatment or other activities appear on the calendar for Saturdays and Sundays.

As part of its investigation, MDLC asked DHS to provide it with a detailed description of groups and treatment modalities. These descriptions were not readily available, and MSH staff were asked to generate descriptions of the various treatment groups for the purposes of responding to MDLC’s request. Most group therapy classes lacked detailed curriculum, programming and course materials. The lack of readily available descriptions and programing materials treatment groups raises questions about how much attention these aspects of treatment receive.

- **One Unit 800 patient’s treatment plan.**

In addition to reviewing unit treatment programs, MDLC looked at patients’ individual treatment plans. Patients each have a forensic “Master Treatment Plan” and an “Individual Treatment Plan” in addition to an Individual Abuse Prevention Plan, Individual Relapse Prevention Plan, and Individual Support Plan. The Master Treatment Plan and Individual Treatment Plan included the same coded treatment areas, often described by a string of adjectives. For example, the description of “107 Emotional State” is: “Depressed. Inappropriately elevated mood. Labile. Pessimistic. Emotionally withdrawn. Lethargic. Feelings of worthlessness. Hopelessness. Irritable. Angry. Emotionally restricted.”

For one patient, the master/individual treatment plan identified the following areas for treatment:

107 Emotional State: The *long term goal* was for the patient to develop and implement a plan to manage mood swings. The *objective* was to “meet with my psychiatric practitioner as requested and accurately describe my mood, symptoms and the effectiveness of my medications until my next review.” The *intervention* was “Offer 1:1 meetings 1x per month as indicated for assessment and medication management.” The *responsible staff* was a nurse practitioner. Quarterly reviews indicated the goal was sometimes met, sometimes not met – “patient stable and engaged at times and ...days later refused medications.” As reflected in quarterly reviews,

⁷⁰ See Appendix D for an example of Unit 800’s Fall Quarter 2014 schedule.

the frequency of interaction with psychiatric practitioner was not increased during periods of instability. Even when met, the goal was always continued.

116 Conduct: History of aggressive behavior. The *long term goal* was to consistently demonstrate safe behaviors. The *objective* was to develop and plan to recognize triggers to anger and manage response to them by the next review.” The *intervention* was 1:1 meetings once a week with a psychologist. In several quarterly reports, the goal was not met and was then discontinued.

119 Coping: The *long term goal* was for the patient to develop and implement a plan to cope with anger and frustration. The *objective* was to practice a new coping strategy one time per month and “discuss effectiveness” until next review. The *intervention* was a coping skills class once a week. The patient did not go to the group and the goal was discontinued.

125 Physical/medical issues: The *long term goal* was to lose weight. The *objective* was to lose a certain number of pounds. The *intervention* was 1:1 meetings offered to provide education and feedback. The patient did not meet the goal and after a few quarterly reviews it was discontinued.

There was not an individual schedule in this patient’s file. There did not appear to be regularly scheduled 1:1 meetings with a named staff, even though indicated as an intervention in the master and individual treatment plans. Individual patient treatment goals and interventions were not correlated to the actual unit activities.

This individual’s treatment plan is a representative example of the deficiencies of treatment that exist for patients at MSH. Patients noted the lack of good treatment as a primary concern when speaking with MDLC. Multiple patients told MDLC that they felt that they were not receiving the care they needed to ameliorate the symptoms of their mental illnesses, avoid incidents leading to restraints, and ultimately return to the community.

FINDING 10: There is not enough individual therapy available at MSH to address the needs of patients who are restrained and secluded.

The patient in the example above, when interviewed by MDLC, did point to the individual therapy that s/he had received as an effective part of his/her treatment. Unfortunately, the individual therapy was conducted by an intern doing a practicum, and was discontinued when the internship ended. Other patients interviewed by MDLC also cited individual therapy as something they wished they could access on a regular basis. More than one patient that MDLC interviewed described individual therapy as very helpful, only to have it end when the student intern’s rotation was completed. Several cited the fact that they were not comfortable in groups, and that they could discuss personal issues more freely in a private, individual therapy session. Some also expressed a preference for individual therapy versus the expectation that they would go to a staff member assigned as a one-to-one when they were having problems.

A common frustration raised in patient interviews with MDLC was that their restraint and seclusion incidents were not routinely discussed in the treatment setting. This is in part due to

the group therapy nature of treatment at MSH, and in part to the lack of coordination between unit staff, facility mental health professionals, and individual therapists.

Patients felt that their treatment could be more effective if it occurred in a setting which allows them to safely talk about their experiences and concerns with restraint or seclusion, and their emotions and fears about these experiences. In addition, patients believed they could not raise what they felt to be legitimate concerns about staff unfairness, arbitrariness, or lack of accountability without those concerns being characterized as a failure on their part – a lack of insight or failure to take responsibility for their actions. Being able to discuss these feelings privately in individual therapy could better help address and resolve these frustrations. Because many individuals are not comfortable with group therapy, individual therapy should be offered to patients as a viable aspect of treatment.

RECOMMENDATION 13: *MSH needs to implement more individual therapy using appropriate mental health professional staff in paid positions.* While a helpful adjunct to a treatment plan, the use of interns is not a long-term sustainable solution. In addition, where a patient has difficulty with group therapy processes, individual therapy may also be a reasonable accommodation required under the Americans with Disabilities Act. Overall, MSH needs to invest more resources into individual therapy as part of its overall treatment programming. In order to have effective individual therapy as part of individual treatment, MSH should have enough qualified mental health professionals on staff to adequately meet the individual therapy needs of patients rather than relying on interns to fill the void.

FINDING 11. MSH relies heavily on security counselors both to deliver daily treatment and to keep order on the units. This presents a conflict of roles that is mostly unacknowledged by hospital management, but well understood by patients.

Security counselors embody the tension between the needs for “treatment” and “safety” at MSH. Even the name “security counselor” evokes conflicting feelings. The state’s “Class Specification” for Security Counselor describes the “Nature and Purpose” of the position as “direct patient care and ward security . . . responsibilities may include providing informal counseling, implementing treatment plans, observing and documenting patients’ behavior, and verbal and/or physical crisis intervention.” The security counselor enforces unit rules, assists patients in meeting daily obligations, and facilitates group meetings and/or activities as assigned.” They are expected to counsel patients “informally” and to follow treatment strategy developed by the professional treatment team.⁷¹

MSH expectations for security counselors emphasize an ability to implement treatment strategies, yet the minimum qualification for this job is as little as a two year associate degree in law enforcement, criminal justice or corrections.⁷²

⁷¹ State of Minnesota Class Specification “Security Counselor” Class Code 000093, <http://www.mn.gov/mmb/images/0093.pdf>.

⁷² Security Counselor job posting 140093000009 (see <http://www.mncounties.org/Employment/Security%20Counselor%20MSOP%20ML%20%209-14.pdf> for an example of this job posting).

For patients at MSH, most daily interactions, treatment or otherwise, are with security counselors. Security counselors act as one-to-ones, run groups and unit activities, and have a major role in determining whether treatment goals have been met. They have significant input in deciding what security level rating a patient gets, and generally are the face of authority for patients institutionalized at MSH. Moreover, security counselors are normally the staff members who restrain and seclude patients.

As patients have told MDLC, this can create a difficult situation for a patient whose assigned one-to-one staff member for personal counseling is also relied on by the team in making a security decision. The patient might want to discuss treatment concerns with his one-to-one, yet does not trust the potential effect of this on his security rating, so does not raise these concerns. As a result, there may be no meaningful progress in addressing patient treatment concerns.

According to the Legislative Auditor, the quality of care at MSH suffers from a lack of meaningful treatment programs. This is in significant part due to the facility's over-reliance on minimally qualified security counselors to implement treatment. Although MSH has recently hired a new medical director and two additional psychiatrists, increased funding for facility personnel has primarily resulted in the hiring and retention of additional security counselors, rather than enriched staffing of positions requiring education and training in providing mental health treatment. In the "Overview of Minnesota Security Hospital Deficiency" prepared for the 2015 Legislature, DHS stated that in 2014 it had increased staffing levels by 58.55 full time employees (FTEs), primarily security counselors; only 18 FTE professional staff were added.⁷³

Furthermore, MDLC found that staff continue to spend significant time apart from patients on the units. DHS licensing reports have criticized MSH staff for spending an excessive amount of time in the unit stations, commonly known as the "bubble," and not enough time interacting with patients on the unit.⁷⁴ In response to these critiques, MSH administration reported changes in policy that require a greater staff presence on the units. Despite these reported changes, MDLC observed during its visits that patients were generally in their rooms or out in common areas, and staff were generally in the office or bubble. Even accounting for shift changes during the times MDLC was present on the units, there was little interaction between patients and staff. MDLC's observations confirm statements made by patients during patient interviews. Patients reported that many staff members spend their time "in the bubble," and not on the unit interacting with patients.

⁷³ *Overview of Minnesota Security Hospital Deficiency*, MINN. DEP'T. HUM. SERVICES (Jan. 2015), [http://www.senate.mn/committees/2015-](http://www.senate.mn/committees/2015-2016/1007_Committee_on_Finance/MSH_Deficiency_summary_012615.pdf)

2016/1007_Committee_on_Finance/MSH_Deficiency_summary_012615.pdf

⁷⁴ *See, e.g.*, DIV. OF LICENSING, MINN. DEP'T HUM. SERVICES, INVESTIGATIVE MEMORANDUM #20140264 (May 20, 2014) (detailing findings of maltreatment).

RECOMMENDATION 14: *In the interest of better patient treatment for all patients, especially those who are frequently restraint and secluded, MSH should review its dual use of security counselors as enforcers and treatment providers, and consider separating some of these functions.*

In order to build therapeutic relationships with patients, security counselors and other staff member should spend more time on the unit interacting with patients in an informal setting. Without these interactions, many patients have negative perceptions of staff members; interactions with staff focus on being given instructions or being punished. Statements by staff to DHS licensing that they are reluctant to go out on the unit because they ‘feel vulnerable’ because of the current seclusion and restraint practices need to be addressed by management, through ongoing and enriched training and clear directives regarding their expectations of staff. At a certain point, staff continuing to resist these more informed, positive approaches should be reassigned.

DHS should evaluate the role of the security counselor role in light of current expectations. When looking at how best to address the serious need for better, more active treatment, while maintaining a safe environment, DHS needs to look at whether some of these security counselor positions should require more professional mental health qualifications.

FINDING 12: **There is not enough contact between psychiatrists and patients at MSH, particularly those patients who are frequently restrained and secluded, and the contact that is available is insufficient.**

Over the last several years, attracting and keeping enough qualified psychiatrists to serve the needs of the MSH patients has been a major challenge. MSH has made progress, hiring a new medical director and two new psychiatrists, and partnering with the University of Minnesota on a forensic residency program. In connection with this effort, it is important for the institution to thoroughly evaluate how these professionals will be utilized by MSH.

The 2013 Legislative Auditor’s report raised a strong concern about the frequency of contact with patients. The report notes that periodic meetings with one’s psychiatrist are “a key component of mental health treatment.”⁷⁵ The Legislative Auditor examined contacts with patients and found that a majority of patients are seen less than monthly. In fact, “in 2010, national consultants told SOS they were unaware of comparable program *in the nation* with standards that allowed, as did the Security Hospital, psychiatrist contacts as infrequently as every three months.” The consultants noted that most programs require monthly contact. The medical director at MSH at the time acknowledged that this was a problem.⁷⁶

In response to this concern, MSH medical staff bylaws now require psychiatric progress notes to be written weekly for the first month of admission, and then quarterly “or more often if clinically indicated.” On acute units, patients may be seen several times per week if necessary.⁷⁷

⁷⁵ 2013 OLA REPORT, *supra* note 15, at 10.

⁷⁶ *Id.* at 109.

⁷⁷ OFFICE OF THE LEGISLATIVE AUDITOR, PROGRESS TRACKING FOR STATE OPERATED SERVICES 9 (Dec. 4, 2014).

However, the *status quo* after the first month of admission is still that a patient is guaranteed to see a psychiatrist once every three months – the same frequency as that criticized by the Legislative Auditor. If MSH is to engage in genuinely active mental health treatment, this ongoing lack of sufficient psychiatric care needs to be addressed.

Importantly, the Legislative Auditor’s report also identified a need by MSH to relate the frequency of psychiatric contacts with particular patients to the expectations set forth in individualized patient treatment plans, and to track and report on this. DHS responded to this recommendation by noting that on acute units, patients can be seen several times per week if necessary and that “this is audited weekly with an automated report from the electronic health record system.”⁷⁸ It is not clear whether anyone, in particular the psychiatric staff, has specific responsibility for tracking this, in respect to evaluating the “fit” of psychiatric contact to the individualized treatment plan. In our review of client records of individuals who were frequently restrained and secluded, MDLC could not find documentation that any of them were seen by a psychiatrist “several times per week.”

RECOMMENDATION 15: All patients should be seen by psychiatrists at least monthly, or more often if called for by individual treatment needs, and particularly when a patient is receiving antipsychotic medications or frequently subjected to restraint and seclusion.
The frequency of psychiatric contacts with particular patients should be tied to expectations set forth in individualized patient treatment plans from the moment the person goes through admission to MSH. National experts have also recommended to DHS that at least monthly contact with a psychiatrist be implemented, in line with comparable programs across the country.

FINDING 13: There are an inadequate number of mental health professionals versed in positive therapeutic procedures that should be implemented in lieu of restraint and seclusion.

According to the 2014 State Operated Facilities Report, the number of psychologists at MSH is 11. The number of Behavioral Analysts is 22. The number of security counselors, including leads, is 271.⁷⁹ This staffing imbalance is directly related to questions of adequate active treatment raised by the Legislative Auditor’s report in 2013 that continue today.

While there are behavioral analysts assigned to each unit, there is not enough focus on positive treatment planning, especially with the patients. Patients are expected to actively engage in their treatment – for example, to identify and implement a plan to deal with behavior – but if the patient cannot do this, or needs help with the process, there is not adequate staff. In treatment plans evaluated by MDLC, some behavioral goals that were continuously unmet continued unchanged even though clearly not working, or were eventually discontinued. In restraint and seclusion debriefings, the lack of professionals who understand positive supports, in particular identification of patient triggers and positive alternatives, has had a direct impact on the capability to successfully reduce the use of restraint and seclusion.

⁷⁸ *Id.*

⁷⁹ 2014 ANNUAL REPORT, *supra* note 27, at 6–7.

The 2013 Legislative Auditor's report noted that at MSH the "amount of time devoted to counseling and psychoeducational activities was quite limited...we found that the average patient had just over one hour per day of scheduled therapeutic activities. This small amount included mental health treatment-related meetings or groups, education courses (such as math, reading, English as a Second Language and drivers' education) and "community meetings" that most residential units held on weekdays."⁸⁰ In contrast, as the Legislative Auditor's report pointed out, the Minnesota Sex Offender Program provided six to eight hours per week of therapy and programming specifically related to the patients' sex offenses.⁸¹ The Legislative Auditor's report concluded that "the *amount and type* of treatment provided...is important, especially given the lengthy stays at this facility that many patients experience, their court commitment of indeterminate length, and the severity of their illnesses. Furthermore, at costs of about \$500 per day per patient...it is reasonable to have high expectations for the services provided."⁸²

Finally, the Minnesota Commitment and Treatment Act requires that "[a] person receiving services under this chapter has the right to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary."⁸³ In order to meet this legal obligation, and facilitate active treatment and patient movement through the hospital's programs, MSH needs more treatment and programming provided by mental health professionals, with direct input by patients, rather than the clinically limited programming now being delivered primarily by security counselors.

RECOMMENDATION 16: MSH should hire additional psychologists, behavioral analysts and other mental health professionals in order to develop and implement positive behavioral and treatment plans for each patient that meet professional standards and reduce the use of restraint and seclusion.

In order for MSH to implement active treatment and patient movement towards discharge, MSH should move away from its reliance on security counselors to deliver most treatment and should employ more mental health professionals to implement and monitor clinical treatment and programming.

FINDING 14. MSH does not have strong relationships with treating professionals from programs in the greater community with expertise to work on targeted treatment issues for high acuity patients who are frequently restrained and secluded.

MDLC's review of the files of patients who frequently were restrained and secluded did not find any use of non-MSH staff to assist in identifying appropriate treatment responses for these complex patients. Every patient is unique, and MSH cannot be expected to address all treatment needs of all patients in-house. It is important for MSH to be able to consult with and bring in experienced professionals to work with particular high-acuity, complex patients. For example, if a patient has a diagnosis on the autism spectrum, a mental health professional with training in the

⁸⁰ 2013 OLA REPORT, *supra* note 15, at 107.

⁸¹ *Id.*

⁸² *Id.* at 106.

⁸³ MINN. STAT. §253B.03, subd. 7 (2014).

unique needs of that person may need to be consulted if the expertise is not available on the MSH campus.

Under the commitment statute, a county also has an obligation to the person it has committed. “[T]he program plan shall be devised and reviewed with the designated agency and the patient...if the designated agency does not participate in the planning and review, the clinical record shall include reasons for nonparticipation and the *plans for future involvement*.”⁸⁴

In addition, if treating professionals from community programs become comfortable and familiar with MSH patients and are able to successfully work with them, they are more likely to see these patients as candidates for their community programs or other similar programs.⁸⁵

Involving community providers to work with individual patients will likewise encourage the flow of patients ready for discharge into the community and may also aid in the community mental health system’s understanding of what additional community resources need to be developed for more specialized patient needs.⁸⁶

RECOMMENDATION 17: DHS should develop community provider resources and collaborations in order to engage the greater community in successful patient treatment, reduce the need for restraint and seclusion, and engender greater development of community services and supports for MSH patients.

Having more flexibility to individually tailor treatment will result in better outcomes at an earlier point in time, less use of restraint and seclusion, and, ultimately, an earlier discharge.

Establishing stronger relationships with community providers would also mean involvement of a broader range of uniquely qualified professionals available to call on for more individualized testing and patient assessments, building relationships and successfully working with patients.

This also has the potential to create more patient pathways to community services. Counties also have an obligation to ensure that the patients they commit are receiving treatment geared toward discharge. Their legally mandated involvement should also include the enlistment of community professionals to aid in this result.

CONCLUSION

The state of Minnesota has made a genuine effort to reform the use of restraint and seclusion at MSH, including an attitude shift to more person-centered treatment and hospital-wide training of

⁸⁴ *Id.*

⁸⁵ Involving community providers has yielded positive result in similar settings. In one example, a psychiatric intensive care inpatient unit in England increased activities inside and outside the hospital, including volunteering at the local Blackpool Zoo. See Arokia Antonysamy, *How Can We Reduce Violence and Aggression in Psychiatric Inpatient Units?* BMJ QUALITY IMPROVEMENT REPORTS 1 (2013), <http://qir.bmj.com/content/2/1/u201366.w834.full.pdf+html>. A study of these changes found that not only were seclusion rates and staff sick days reduced significantly, but staff had become “more geared to positive risk taking”, resulting in successfully discharging more patients directly from the unit to the community, instead of requiring them to go to step down settings. *Id.* at 2.

⁸⁶ In order for MSH to better facilitate these outcomes and also meet its *Olmstead* obligations, DHS should also address its attention to issues of assumption of risk and indemnification of community providers, a complex discussion beyond the scope of this report.

staff. Yet the changes accomplished thus far fall short of the successes illustrated by other programs that have reformed their use of restraint and seclusion. MSH is still not proficient in its ability to identify antecedents and implement early interventions. Its debriefing and treatment adjustment process is not consistently applied and evaluated, and not particularly responsive to genuine patient needs. MSH rarely provides active individualized treatment, particularly for high acuity patients who are frequently the subject of seclusion and restraint. For these patients, movement through the current treatment process is slow and repetitive, creating frustration for patients and staff.

Active, individualized treatment can lead to a sustained and permanent reduction in aggressive behaviors that call for the use of restraint and seclusion. Greater involvement of community resources and know-how in treating these complex patients will also yield results in aid of this objective. Recognition and acceptance that these patients are capable of responding to positive treatment, a deeper understanding of alternative practices, a maximum effort inspired by leadership, and sincere cooperation by all parties are the essential components of reducing and eliminating restraint and seclusion, reducing patient and staff injuries, and providing mental health care that will enable a successful return to the community.

As set forth in this report, there is much work to be done to improve the situation for patients at MSH. However, with sustained and genuine efforts from all parties involved, MSH can become a model for restraint reduction and recovery, and a hospital that the citizens of Minnesota respect and support.

APPENDIX A

Effective Date: 07/01/2015

Procedure Number: 10005

Medical

Restraint & Seclusion

SOS REFERENCE POLICY NUMBER: N/A

DEFINITIONS:

Imminent Risk: A behavior that is likely to cause harm to self or others that is highly likely to occur in the immediate future.

Emergency Intervention: Restraint or seclusion of a patient which is necessary to protect the patient or others from imminent risk of harm.

Restraint: Restraint means any physical device that limits the free and normal movement of body and limbs as defined in Minnesota Rule 9520.0510, Subp. 25. When staff need to use restraint, they will use the techniques currently endorsed by the organization. All restraints listed are used to maintain safety for patients and staff. The emergency intervention used is the least restrictive intervention that will effectively react to the emergency and the use of the emergency intervention must end when the threat of harm ends.

1. Manual restraint – placing hands on an individual for the purpose of restricting movement
2. Velcro restraint – wrist, ankle and arm
3. Handcuffs
4. Body Wrap – upper body and ankle
5. Spit Hood – see definition under spit hood
6. Transport Device – medical device used for the purpose for moving a patient from one area to another, i.e., medical gurney or Reeves stretcher. The patient will be restrained when the device is used maintain safety.
7. Posey Ambulatory Belt – used for transporting patient in Reeves stretcher
8. Shield/Body Pad – see definition below under shield/body pad
9. Mobile restraint – one point or two point
10. Restraint chair – up to six point (see campus-wide procedure #10005/54000)
11. Restraint to bed – up to four point

Restraint does **not** include the following:

1. Braces
2. Any devices or belts which are used to maintain posture or to keep a patient from falling, which does not require assistance for release
3. Helmets
4. Brief acute medical or surgical care, standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures, IV arm boards, and radiotherapy procedures
5. Use of restraints for transport outside the secure perimeter (see campus-wide procedure #10006/63550)

Seclusion: Seclusion means involuntary removal into a separate room which prevents social contact with other persons as defined in Minnesota Rule 9520.0510, Subp. 26. Seclusion involves a locked room or preventing the patient from physically leaving an area.

Shield or Body Pad: A device used as a barrier by staff to protect staff and other patients. If the shield is utilized to limit the patient from physically leaving an area, it is considered seclusion. If the shield or body pad makes physical contact with a patient to allow staff to utilize other restrictive procedures, it is considered a restraint.

Spit Hood: a hood placed over patient's head to prevent contamination and risk of infection in situations where the patient is actively spitting.

Therapeutic Interventions: Individualized verbal and behavioral strategies to engage individuals in active treatment based on empathy, respect and positive regard for the people receiving services.

Medical Practitioner: Licensed Physician, Nurse Practitioner (includes APRN) and Physician Assistant.

Behavior Management Review Committee (BMRC): A committee which reviews the use of restrictive treatment procedures, including but not limited to restraint and seclusion reviews, money management plans, mail plans, etc.

RESPONSIBILITIES: The Forensic Medical Director or designee is responsible for the implementation of this procedure and to assure that staff is aware of and receive training on this procedure and ensuring the application is in accordance with this procedure.

PROCEDURES:

- A. Our organization's philosophy regarding restraint and seclusion includes a commitment to:
 - 1. Reduce and strive to eliminate the need for restraint and seclusion through improvement of therapeutic alliances with the individuals we serve;
 - 2. Reduce and strive to eliminate emergencies that have the potential to lead to the use of restraint or seclusion;
 - 3. Non-physical interventions as preferred interventions based on positive engagement;
 - 4. Limit the use of restraint and seclusion to emergencies in which there is an imminent risk of a patient physically harming themselves or others;
 - 5. Discontinue restraint or seclusion as soon as imminent risk of harm is resolved;
 - 6. Raise awareness among staff about how the use of restraint or seclusion is coercive and recognize that coercive interventions cause trauma both for the people we serve and staff;
 - 7. Preserve the patient's rights, safety and dignity when restraint or seclusion is used.

- B. Non-physical therapeutic interventions are the first choice. Restraint or seclusion of a patient is only used when necessary to protect the patient or others from imminent risk of harm. While most patients will never experience restraint or seclusion, all are assessed for their risk of requiring these interventions.

- C. Special considerations to this procedure:
 - 1. Procedure does not apply to Forensic Nursing Home;
 - 2. Seclusion will not be used in Transition Services;
 - 3. If the patient is on a Rule 20 status only, the patient must be placed on an emergency hold; and
 - 4. If a patient is on a voluntary return from provisional discharge status, revocation of the provisional discharge shall be addressed.

D. Assessing the risk for Restraint and Seclusion:

1. An evaluation is completed by a Medical Practitioner within 24 hours of admission. The evaluation identifies a patient's pre-existing medical conditions or any physical disabilities and limitations that place them at greater risk during restraint or seclusion. This information is documented in the Physical Activity and Intervention Clearance Order.
2. All patients are assessed to determine if they are at risk of harming themselves, staff, or others and this information is documented on their Individual Abuse Prevention Plan (IAPP) within 8 hours.
 - a. The assessment includes the patient's history of physical, sexual, or emotional abuse. The IAPP also identifies the risk the patient might reasonably be expected to pose to visitors to the facility and persons outside the facility if unsupervised.
 - b. The information related to the patient's risk of harming themselves or others identified in the Physical Activity and Intervention Clearance Order will be included in the patient's IAPP.
 - c. The IAPP will identify the specific vulnerabilities or risks for the patient and the measures that will be taken to reduce those risks.
3. Patient triggers that can cause agitation, and calming strategies that can be used to reduce agitation are documented in the Initial Treatment Plan completed within 8 hours following admission and reviewed and/or updated monthly or quarterly per program guidelines in the patient's Individual Treatment Plan. Information may also be included in a patient support plan.
4. The patient and their family, if appropriate, are informed upon admission of the philosophy on the use of restraint and seclusion unless clinically contraindicated. The role of the family, including their notification of a restraint or seclusion episode, is discussed with the patient and, as appropriate, the patient's family and documented on the Patient and Family Restraint and Seclusion Notification Form. This form will be updated annually or as requested by the patient.

E. Consideration of Supportive Interventions:

1. The least restrictive interventions must be considered first. The supportive interventions utilized need to be documented in the patient's medical record, either as a progress note or as part of the Intervention Data Form if a restraint or seclusion intervention occurred.
2. Refer to the patient's individualized treatment plan or support plan for supportive interventions tailored to assist the patient to reduce distress and improve problem solving abilities.
3. Seek out a staff person who has good rapport with the patient to see if that staff person can assist the patient to engage in therapeutic interventions to reduce distress and improve problem solving abilities.
4. Describe the feelings that may be contributing to distress; e.g., "I can see that you are angry" (or afraid, etc.) and encourage the patient to verbalize his/her concerns.
5. Confer with patient, nurse or medical practitioner regarding medication or other alternatives that could assist the patient to regain control and feel safe.
6. Encourage use of sensory room if available.

F. Implementing Restraint or Seclusion:

1. Staff may initiate the use of manual restraint only when necessary to protect the patient or others from imminent risk of harm. Staff must document the behavior that required the use of manual restraint on the Intervention Data Form.
2. All uses of restraint and seclusion must be assessed and authorized by a RN or Medical Practitioner. An order for the use of restraint or seclusion must be obtained from the Medical Practitioner.
3. Consideration of patient dignity and privacy will be of highest priority. The minimum amount of intervention will be utilized for the shortest period of time to meet safety concerns.

4. A sufficient number of staff shall be present and/or requested to be present to protect the patient and others from injury.
5. In all instances of the application of a restraint procedure, the treatment plan, Physical Activity and Intervention Clearance Order and Individual Abuse Prevention Plan for the patient must be followed.
6. If the patient is restrained in a prone/supine position, they must be placed on their side as soon as possible. Nursing staff must ensure that the airway is unobstructed and the expansion of the patient's lungs is not restricted.
7. If the spit hood is used for a patient actively spitting, a nursing staff will be present.
8. If the patient is placed in the restraint chair the patient will be searched for contraband and potentially hazardous objects. If the patient is placed in seclusion, the patient and room used for seclusion will be searched for contraband and potentially hazardous objects.
9. A mattress, blanket, pillow and clothes must be provided to all secluded patients unless clinically contraindicated through assessment by a Medical Practitioner. Removal of any of these items requires an order. A tear proof gown must be provided at the time the clothes are removed.
10. Secluded patients shall be offered access to items which may assist them to regain control provided that such access does not endanger self or others. All patients' requests for items will be documented. If such requests are denied, the justification for the denial will be documented.
11. At the initiation of the restraint or seclusion the patient will be made aware of the rationale for the restraint or seclusion and the release criteria to discontinue the intervention. If the patient's behavior is assessed as clinically being unable to understand this verbal information (is yelling, pounding on the walls, or demonstrating other behavior that is making it impossible to communicate); this information will be given to them as soon as they are assessed to be able to hear it. Additional release criteria included in the Medical Practitioner's order will be provided to the patient after the order has been received.
 - a. The level of self-control the patient must exhibit in order to be released must be documented in the Medical Practitioner's order. If the RN determines the patient can be released from restraint or seclusion prior to obtaining the order from the Medical Practitioner, the RN will inform the Medical Practitioner of the patient's behaviors which prompted his/her release so that these behaviors can be included in the release criteria portion of the order.
 - b. The patient's response to being informed of the release criteria must be documented on the Intervention Data Form.
 - c. The criteria must be renewed every four hours for an adult patient and within two hours for a patient under age 18, if not met. The time of the initial order starts with the initiation of the intervention.
11. Restraint or seclusion will be discontinued when the patient has met the release criteria. Unless otherwise specified in the release criteria, behavior such as sleeping is considered as being calm and in self-control and meets criteria for release.
12. The patient's family is notified of the initiation of restraint or seclusion if the patient and family have agreed to be notified. Refer to the "Patient and Family Restraint and Seclusion Notification" Form. (Document on Intervention Data Form)
13. The Medical Practitioner will notify the Forensic Medical Director or designee of instances in which a patient remains in restraint or seclusion for more than twelve hours or the patient experiences two or more separate episodes of restraint or seclusion of any duration within 12 hours. Thereafter, the Forensic Medical Director or designee is notified every 24 hours if either of the above issues continues.

G. Monitoring of Patients in Restraint or Seclusion

1. Patients in restraint or seclusion are continuously monitored to ensure their physical safety.

- a. Monitoring is accomplished through continuous in-person observation by Nursing staff during the first 30 minutes of continuous observation. If the spit hood is used, nursing staff will continue to provide the required monitoring. An assigned staff member will relieve the nursing staffing after the first 30 minutes and provide continuous observation until the patient is released.
 - (1) Restraints (for example, manual, body wrap, spit hood, chair or bed): one-to-one observation (no physical barriers are allowed between staff and patient)
 - (2) Seclusion: continuous observation (observation may be conducted through glass walls or windows that do not obstruct view)
 - b. If the patient's behaviors interfere with the ability to maintain continuous observation, contact the Medical Practitioner immediately. The Medical Practitioner may authorize the use of a camera to observe the patient in the room if unable to maintain visual contact through the window.
 - c. If it is consistent with the patient's condition or wishes and, if clinically appropriate, simultaneous video and audio equipment may be used for seclusion for continuous monitoring after the first hour.
2. The RN will assess the patient at the start of restraint or seclusion and every 15 minutes thereafter, and document assessment findings on the RN Assessment Form. The RN will determine if nursing monitoring can be discontinued after 30 minutes. If discontinued at 30 minutes, this will be documented on the RN Assessment Form. If the RN does not feel that nursing monitoring can be discontinued based on the patient's physical status, the RN must contact the Medical Practitioner regarding the physical assessment of the patient. This assessment includes the following as appropriate:
 - a. Signs of any injury associated with restraint or seclusion
 - b. Nutrition/hydration
 - c. Circulation and range of motion in the extremities
 - d. Vital signs
 - e. Hygiene and elimination
 - f. Physical comfort
 - g. Psychological status
 - h. Readiness for discontinuation of restraint or seclusion
 3. The patient may not be secluded in a room that does not have a toilet.
 4. Meals are to be provided and documented at usual intervals, using disposable utensils, plates and cups as necessary.
 5. If access to fluids is restricted, normal fluid intake will be offered with meals and medications. All offers, acceptance and refusals of fluids and meals shall be documented on the Observation Data Form.
 6. The cleanliness of the seclusion area and hygiene of the patient shall be maintained.
 7. If the patient has not met release criteria within four (4) hours for an adult patient and within two (2) hours for a patient under age 18, the Medical Practitioner will issue a new order.
 8. The Medical Practitioner must do an in-person evaluation within four (4) hours of the initiation of restraint or seclusion for adult patients and within two (2) hours for a patient under age 18. The Medical Practitioner must do an in-person assessment at least every eight (8) hours for adult patients, and four (4) hours for a patients under age 18 thereafter until the patient is released.
 9. If the patient is no longer in restraint or seclusion when an original order expires, the Medical Practitioner must conduct the in-person evaluation of the patient within 24 hours of the initiation of restraint or seclusion.
 10. During the Medical Practitioner's in-person evaluation they will:
 - a. Work with the patient and staff to identify ways to help the patient regain control.
 - b. Recommend possible revisions to the patient's treatment plan to the designated treatment plan author.

- c. If necessary, provide a new written order.
- 1. In the event of a fire, the staff person assigned to continuously monitor the patient in restraint or seclusion is responsible for the evacuation of the patient from the immediate area of danger as governed by Campus-wide Procedure 10008, "Fire Response and Reporting."

H. Release from Restraint or Seclusion:

- 1. When the Registered Nurse or Medical Practitioner has determined that the patient meets the release criteria, that person will inform the unit staff, who will facilitate the patient's release from restraint or seclusion and the successful return to the milieu.
- 2. The patient, and if appropriate, the patient's family, will participate in a debriefing with available staff who were involved in the episode. The debriefing will be conducted by the assigned RN. A debriefing will occur as soon as is possible and appropriate, but no longer than 24 hours after the episode.
- 3. The debriefing will:
 - a. Attempt to re-establish a therapeutic alliance with the patient.
 - b. Identify what led to the incident and what could have been handled differently.
 - c. Determine that the patient's physical well-being, psychological comfort, and right to privacy were addressed.
 - d. Counsel the patient involved for any trauma that may have resulted from the incident.
 - e. Make recommendations to modify the patient's treatment plan to the designated treatment plan author.
- 4. If the patient chooses to not participate in the debriefing:
 - a. A staff person who is able to engage with the patient will attempt to meet with the patient.
 - b. The staff person will bring patient's experience to the treatment team.
 - c. The staff person will bring back team recommendations to the patient.
- 5. Release will be documented by the nurse on forms related to restraint and seclusion.

I. Documentation of the Use of Restraint or Seclusion:

- 1. The Intervention Data Form will be completed by assigned staff. Staff will describe how the patient was manually restrained on the Intervention Data Form, i.e., placed right hand on patient's left wrist and left hand on left shoulder, if the patient was placed on the floor, etc. The different supportive interventions attempted must be documented on the Intervention Data Form or referenced made to a specific progress note in the patient's medical record. Description of the behavior that demonstrated imminent risk will be documented on the Intervention Data Form.
- 2. The RN Assessment Form will be completed by the RN.
- 3. The Incident Report will be completed by assigned staff.
- 4. Writing the order for Restraint or Seclusion:
 - a. An order for the use of restraint or seclusion must be obtained from the Medical Practitioner within 60 minutes of initiation of the intervention. If the RN determines the patient can be released from restraint or seclusion prior to obtaining the order from the Medical Practitioner, the RN will inform the Medical Practitioner of the patient's behaviors which prompted their release so that these behaviors can be included in the release criteria portion of the order.
 - b. The Medical Practitioner's order will specify:
 - (1) The behavior necessitating the initiation of the intervention.
 - (2) The behavior the patient must exhibit in order to be released.
 - (3) The observation level.
 - (4) The time limits: the order will be time limited to four (4) hours for an adult patient and two (2) hours for patients under age 18. The time of the initial order starts with the initiation of the intervention.

- c. There must be a new Medical Practitioner's order for:
 - (1) Each type of restraint or seclusion used;
 - (2) A change in the time limits for restraint or seclusion;
 - (3) A change in the criteria for release;
 - (4) A change in the type of monitoring;
 - (5) Release criteria that was not met within four (4) hours for adult patients and within two (2) hours for a patient under age 18.
 - (6) Release criteria for restraint chair that was not met within 2 hours.
- d. The Medical Practitioner will complete a progress note for each face to face evaluation.
5. The Observation Data Form will be completed by the staff assigned to do the observation.
6. The Data Entry Form will be completed by nursing and sent to the Data Entry person.
7. The forms related to restraint and seclusion will be filed in the medical record immediately after the documentation of the intervention is completed.

J. Review of Intervention:

1. The Area Supervisor, i.e., Unit Director or RN Administrative Supervisor, will complete the Restraint and Seclusion Audit of each use of restraint and seclusion within 7 days of release. The review will ensure that all required documentation has been completed.
2. The Restraint and Seclusion Audit form will be forwarded by the Area Supervisor to the Program Director for review.
3. The BMRC will review Restraint and Seclusion incidents according to the BMRC procedure.
4. The Clinical Management Committee or Leadership Team will review aggregate data monthly to identify patterns of restraint and seclusion, reduce usage, evaluate efficacy and recommend improvement strategies.

K. Staff Training: Staff implementing restraint or seclusion must have documented annual training related to its use.

DATA PRIVACY: All staff will comply with MN Statutes, Chapter 13 of the Minnesota Government Data Practices Act, and the Health Insurance Portability and Accountability Act (HIPAA) to ensure the privacy of patients and other individuals.

REFERENCES:

Forensic Services 10005-Observation Levels
Forensic Services 10005-Restraint Chair
SOS Policy 2020-Incident Reporting and Management
Forensic Services 10006-Use of Restraints for Transport Outside the Secure Perimeter
Forensic Services 10008-Fire Response and Reporting
Avatar Data Entry Form & Instructions
Family Notification Letter
Restraint and Seclusion - Intervention Data Form SOFS #11-114
Restraint and Seclusion – Intervention Data Form – Additional Documentation – SOFS-SP #11-114B
Observation Data Form – SOFS #11-116
Patient and Family Restraint and Seclusion Notification – SOFS # 11-115
Restraint and Seclusion - RN Assessment Form - SOFS-SP #11-113A
Restraint and Seclusion - RN Assessment Extender Form – SOFS-SP #11-113B
Restraint and Seclusion – Debriefing – SOFS-SP #11-112
Audit - Restraint and Seclusion

CANCELLATIONS: The procedure supersedes Forensic Services Procedure #52100, dated 08/21/2014.

AUTHENTICATION SIGNATURE:



Forensic Medical Director

APPENDIX B

Current Structure and Staffing at MSH

1. **As of March 2015, State Operated Forensic Services (SOFS) had 386 budgeted beds and 367 utilized beds on the MSH campus.**⁸⁷

The patients in the Security Hospital proper are assigned to one of the following units and their programs:

- **Admissions and Crisis Care (Unit 800):** Serves men admitted to MSH, along with men who are in need of crisis care and stabilization. MSH has also remodeled a medical area to be an admission and evaluation unit of 4 beds; that unit opened in December 2014.
- **Life Skills Unit (Unit 200):** Serves those whose mental health treatment needs are related to a cognitive impairment, including brain injury, fetal alcohol and developmental/intellectual disabilities.
- **Rehabilitation and Recovery (Unit 300):** The primary focus of treatment centers on illness management, skills training, and psychosocial rehabilitation. Social integration outings occur off the unit, for the purpose of demonstrating skills learned in treatment.
- **Special Needs Services (Unit 600):** Provides specialized treatment to adult males with impaired cognitive abilities who are in need of sexual disorder treatment.
- **Rehabilitation and Recovery 2 (Unit 700):** Provides treatment to individuals with a variety of diagnoses and personality disorders, focusing on pro-social behaviors and adaptive social integration.
- **New Outlook (Unit 900):** Serves almost all women admitted to MSH, along with new admits and those in need of crisis care and stabilization. All groups are based on the 900 unit.
- **Social Learning Program (South Unit):** Serves patients with negative symptoms of major mental illnesses, such as social isolation or paranoia, in a setting that reinforces participation through a token economy system.
- **Transition Readiness (Bartlett Hall 2-North and 2-South):** Serves men and women who are stable and are ready to prepare for discharge from MSH.
- **Bartlett 1-South** is a specialized unit for individuals who are in need of intensive support for participation in treatment and interacting with others.
- **Medical/Psychiatric Unit (Bartlett 1-South):** Provides mental health care and treatment for individuals who need assistance with activities of daily living.
- **Competency Restoration Program (Unit 100)** provides treatment and evaluation of individuals who have been committed for restoration of competency to participate in criminal proceedings. As of Jan. 1, 2014, 31 individuals were

⁸⁷ MINN. DEP'T OF HUMAN SERVS., CENSUS REPORT (March 2015).

- being served in the program. However, additional competency restoration beds have been added to the CRP as the Young Adult and Adolescent Program (YAAP) has been phased out of Unit 100. The steep rise in the CRP numbers is due to a 2013 change in the law requiring DHS to provide competency services within 48 hours of a Rule 20 commitment order.⁸⁸ Assessment and placement of these individuals, often arriving untreated, have created tensions for both patients and staff.

In addition, two other programs located on the St. Peter Regional Treatment Center are not technically part of the “Minnesota Security Hospital,” but are relevant to the content of this report. **Transition Services** provides a supervised residential setting to people committed as mentally ill and dangerous who have progressed through treatment and have been approved for a reduction of custody by the Special Review Board, the commissioner of Human Services or the Supreme Court Appeal Panel. The program is located on the St. Peter campus, outside of the secure treatment environment of MSH. It is budgeted for 82 beds; currently, 80 are being served in the program.

The **Forensic Nursing Home** provides services for people in need of a nursing home level of care on medical release from the Minnesota Department of Corrections or who have been committed as mentally ill and dangerous, a sexual psychopathic personality or a sexually dangerous person. The Forensic Nursing Home was considered part of MSH until February 2014. As of the March 2015 census report, **33 residents** were being served in the program. The nursing home is located in a separate building on the St. Peter campus.

Interestingly, patient transfers from MSH to Transition Services or the Forensic Nursing Home are considered “discharges” for purposes of reporting to the *Olmstead* Subcabinet, in order to meet discharge expectations under the state’s *Olmstead* community integration plan mandated by the *Jensen* court.⁸⁹

2. Staffing at MSH: As of July 1, 2014, there were 743 direct care Full Time Employees in State Operated Forensic Services. The categories of staff include:

- 22 behavior analysts,
- 40 human services support specialists,
- 4 psychiatric advance practice nurses (APRNs),
- 83 nurses,
- 11 psychologists,
- 16 behavioral medical practitioners,
- 271 security counselors, including 49 security counselor leads.⁹⁰

⁸⁸ MINN. STAT. § 253B.10, subd. 1(b).

⁸⁹ Minnesota’s *Olmstead* Plan requires MSH to discharge ten (10) individuals per month by December 2015. *Putting the Promise of Olmstead into Practice: Minnesota’s 2013 Olmstead Plan* MINN. DEP’T. HUM. SERVICES (proposed modifications March 20, 2015),

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Render=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_193693

⁹⁰ 2014 ANNUAL REPORT, *supra* note 28.

APPENDIX C

Summary of reports addressing safety, staffing, and seclusion and restraint at MSH.**a. DHS Licensing Report December 2011, placing MSH on a conditional license:**

The conditional license at MSH, which has been extended until 2016, was a result of violations stemming from a May 2011 DHS licensing inspection. This inspection found 21 licensing violations, 8 of which were related to restraint and seclusion, and which resulted in substantiated findings of maltreatment by the facility itself, and by individual staff.⁹¹ In one instance of maltreatment, a patient was placed into a prone restraint in violation of his Individual Abuse Prevention Plan, which had specifically identified prone restraint as a safety risk for this patient due to respiratory depression and obesity. In another incident cited as maltreatment, a patient was in seclusion (“protective isolation”) for 115 days, and slept on a concrete slab with no mattress for 25 of those days.⁹²

Of particular concern, the licensing division found that MSH violated state rules prohibiting restraint and seclusion as a form of punishment and for the convenience of staff. Licensing found inadequacies in the policies themselves and in their application to patients. For example, handcuffs and “mesh wraps” were used on patients, but were not considered restraints by MSH staff.⁹³ The licensing report noted that patient files “often did not contain documentation to support the imminent risk of physical harm to the patient or others...one resident file described the behavior precipitating a physical hold as “verbally aggressive and crossing physical boundaries” and another as “verbally aggressive in staff’s face.”⁹⁴ Noncompliant use of restraint and seclusion and inadequate supporting documentation, identified as problems in 2011, continue to be problematic today.

b. Legislative Auditor’s Report (February 2013):

In 2013, the Office of the Legislative Auditor completed a report to the Legislature on State-Operated Human Services, including the Minnesota Security Hospital. The report raised concerns that many patients have stayed at MSH for years, for a variety of reasons. It noted that MSH “has had ongoing management problems for years, with unresolved questions about the balance between security and treatment” for patients. The report cited too few psychiatrists and too little in the way of placement efforts and options.⁹⁵

⁹¹ *Determination of Maltreatment, Order to Pay a Fine, and Order of Conditional License, License Number. 801558 – Minnesota Security Hospital*, DIV. OF LICENSING, MINN. DEP’T HUMAN SERVS. 2 (Dec. 22, 2011), http://www.dhs.state.mn.us/main/idcplg/%7B20267F8D-41CC-4642-9241-D971733CA97D%7D.doc?IdcService=GET_FILE&dID=128002&dDocName=LLO_12847&allowInterrupt=1 (referencing DIV. OF LICENSING, MINN. DEP’T HUMAN SERVS., DHS LICENSING DETERMINATION OF MALTREATMENT, LICENSING REPORTS 20103702,20103327 8–9 (December 22, 2011)).

⁹² *Id.*

⁹³ *Id.* at 8.

⁹⁴ *Id.* at 11.

⁹⁵ 2013 OLA REPORT, *supra* note 15, at xii.

The report also looked specifically at the use of restraint and seclusion in state operated facilities between January 2011 and June 2012. It found that different facilities differed in the extent and types of restraint and seclusion used. The Children's and Adolescent Behavioral Health Hospital used the most restraints, 958 instances of physical holds. MSH had a total of 776 instances of seclusion and restraint. However, what was considered a restraint, for example handcuffs, was unclear, creating an uncertain picture of actual use.⁹⁶

Even more importantly, the report found that the failure of management "to develop sound policies and practices regarding the use of restraint and seclusion had negative effects on patients and entire facilities."⁹⁷ Restraint and seclusion practices at MSH were described as "problematic over a period of many years," and that responsibility for the ongoing problems rested with SOS management.⁹⁸ The report concluded that oversight of restraint and seclusion should not be left to individual facilities but that DHS "should designate a 'top official' to ensure compliance with appropriate standards at all SOS facilities."⁹⁹

c. Jensen Federal Court Monitor Phase 1 Review Report (October 17, 2013):

The *Jensen* federal court settlement in 2011 included an agreement by DHS that prohibited all uses of mechanical restraint and seclusion, except in cases of emergency. A subsequent evaluation by Court Monitor David Ferleger was conducted with the intent to "examine 2012 and 2013 restraint and seclusion use, consider compliance issues, and encourage DHS's continued, positive and prompt attention to these important issues."¹⁰⁰ The Court Monitor evaluated aggregate data from DHS which indicated significant use of seclusion at MSH. "[F]or clients with DD and MI, the average use of seclusion for months in which seclusion was used was 539 minutes (9 hours). The high month use was 2,602 minutes (43 hours)."

The Court Monitor concluded that DHS was continuing its practices regarding seclusion and restraint procedures, unlike the MSHS Cambridge program, which had prohibited these procedures.¹⁰¹ The Court Monitor has requested additional data focusing on individuals' experiences for a follow up Phase 2 report.

⁹⁶ *Id.* at 61.

⁹⁷ *Id.*

⁹⁸ *Id.* at 65.

⁹⁹ *Id.*

¹⁰⁰ Restraint Chair and Seclusion Use at AMRC and MSH: Phase 1 Review, *Jensen*, 2011 WL 6178845 (2013) (No. 09-cv-01775-DWF-FLN), ECF No. 236.

¹⁰¹ See generally Anne Barry, *Transition of Minnesota Specialty Health System (MSHS)-Cambridge to Minnesota Life bridge: Admission and Discharge Processes, Transition Planning and Community Mobile Support Services*, MINN. DEP'T HUM. SERVICES (Apr. 29, 2014) http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_183312.pdf (describing the transition process upon closure of MSHS Cambridge).

d. SOFS FY2013 and FY2014 Annual Reports:

State Operated Forensic Services (SOFS) provides additional data regarding the use of restraint and seclusion in its annual reports. For FY2013, graphs show that restraint hours went from a high of around 160 total hours in November 2012 to a low of around 20 hours in May 2013. In 2014, the high was around 80 hours in February 2014; the low as around 5 hours in October 2013, a significant downward trend.¹⁰² Seclusion hours ranged from around 275 hours in August 2012 to around 5 hours in October 2014.

The percentage of patients restrained has vacillated from 7% in July 2012 to around 2% in February 2013, and up and down from 3.5% to 5% in FY2014. According to the report, the Behavior Management Review Committee and Clinical Management Committee review the use of restraint and seclusion on a regular basis. Percent of patients in seclusion has run the gamut from over 4% in August 2012 and June 2013, with lows of 2% in several months. The last reported month, June 2014, shows around 3% of patients being in seclusion.¹⁰³

Patient satisfaction surveys were conducted on all units. 82% of patients responded. Responses often varied from unit to unit but several items were common in low response rates. Mid 50% range included “I feel involved in decisions that affect my unit”-53%, and “My peers are respectful to others and try to get along”-56%. Scoring in mid to low 60% range: “I am involved in meaningful treatment”; “My treatment team cares about me”; “I trust my treatment team”; “I am treated with respect”; “I am involved in setting up my treatment plan”; “I feel informed about what is happening in the hospital”.

The reports also describe a number of achievements. In FY2013, a new restraint and seclusion policy was enacted. Use of handcuffs for outside trips has been revamped to allow off campus trips without cuffs “if behaviorally able to do so.” Partnerships with the NASMHPD and Mandt training have provided additional resources for consultation, staff training and culture change. Additionally, training has been offered in non-violent communication, person-centered thinking and trauma-informed care. A goal of continually reducing the use of restraint and seclusion is also in place. According to the report, a work group is currently looking at the amount of treatment provided to individual patients at MSH to improve the quality and quantity of treatment activities offered.¹⁰⁴ In 2014, the report cites the bonding bill for a new building, which will enable programs to be centralized in one location. It also points to the expansion of the Recreational Therapist Department, to increase the number of activities at MSH.¹⁰⁵

¹⁰² 2014 ANNUAL REPORT, *supra* note 28, at 16–17.

¹⁰³ *Id.* at 18.

¹⁰⁴ STATE OPERATED FORENSIC SERVS., FISCAL YEAR 2013 ANNUAL REPORT 35 (2013).

¹⁰⁵ 2014 ANNUAL REPORT, *supra* note 28, at 37.

e. Department of Human Services/Minnesota Department of Health licensing investigative memorandum (May 20, 2014) finding maltreatment on Unit 800 in the beating death of a patient at the hands of another patient:

On May 20, 2014, DHS licensing issued a report on the murder of one patient by another patient on Unit 800 on January 24, 2014. The patient who committed the murder was originally committed to the Competency Restoration Program (CRP), and then transferred to Unit 800 after assaulting a patient on the CRP unit. The investigative report found that his potential for further assault was not clearly evaluated, and he was not under continuous observation by staff. The investigative report identified more than one request by the patient who committed the murder to see a doctor about medication on the day of the fatal assault, but none of the requests were granted.

Staffing complements, and patterns of staff behavior, were a major focus of this licensing investigation. The investigators noted that staffing levels on Unit 800, with its complex array of patients, were the same as for the rest of the hospital – 5 security counselors for up to 16 patients. 14 patients were on the unit on the day of the incident. No additional training had been provided for these staff. In addition, a RN and LPN were present on the unit, but were not directly responsible for supervision of patients. All had been trained on trauma informed care and MANDT, a specialized training on proper manual holds.

Although there were 5 staff members on the unit for the 14 patients, the investigation found that these staff spent much of their time in the office bubble and not on the unit with the patients. Some staff said they felt vulnerable and uncertain on how to implement the new seclusion and restraint policy.

Hourly checks viewing each patient's face were required on Unit 800, but these were not consistently done. On the night of the patient's death, these checks were either not done between 5:00 pm and 7:30 pm, or not done with facial view as required by the policy. Some areas of the unit are not visible from the bubble or common areas, even though Minnesota Statutes Section 245A.65 requires that physical plant conditions must be safe for clients. Complicating the visibility issues, staff were allowing patients to be in each other's rooms, including those like the victim's, which they were not able to visually monitor from the bubble area.

Surprisingly, the investigation found that staff had not reviewed the treatment and abuse prevention plans of the two patients involved in the incident. According to staff, they were not required to read IAPPs and ITPs of the patients they worked with. However, Minnesota Rule 9520.0640 requires IPPs "to be used by the staff." In addition, Minnesota Statute Section 245A.04 requires the facility to monitor implementation of policies/procedures, including those applicable to staff responsibilities. While the physical plant was deficient, "there remain significant issues directly related to the personnel, education, training, and leadership."¹⁰⁶

¹⁰⁶ *Determination of Maltreatment, Order to Pay a Fine, and Order Extending the Facility's Conditional License, License Number. 801558 – Minnesota Security Hospital, DIV. OF LICENSING, MINN. DEP'T HUMAN SERVS. 3 (May 20, 2014), available at*

The report concluded there was maltreatment due to neglect of a vulnerable adult. The security counselor responsible for rounds, and the MSH facility were each responsible for the maltreatment. However, the security counselor was not disqualified from providing direct care services as a result of the maltreatment, but was notified that any further substantiated act of maltreatment would result in disqualification.¹⁰⁷ DHS licensing ordered MSH to submit an action plan to licensing, including expectations for patient and room checks, staff responsibility for understanding and implementing abuse prevention and treatment plans, and increasing supervision on Unit 800.¹⁰⁸

f. DHS Licensing Investigative Memorandum and Correction Order (October 28, 2014):

On October 28, 2014, the DHS licensing division issued a violation and correction order based on the use of restraint on one patient. This investigation is of particular importance, because the alleged maltreatment occurred after the implementation of the current restraint and seclusion policies. DHS licensing found that MSH violated state law by failing to monitor the implementation of its policy on restraint and seclusion. However, the investigation was inconclusive as to maltreatment, because “the poor documentation made it unclear whether the issue was a failure to provide reasonable and necessary treatment, or was a documentation issue, there was not a preponderance of the evidence as to whether there was a failure to provide the VA with reasonable and necessary care.”¹⁰⁹

DHS Licensing reviewed all February 2014 incidents of restraints of a patient who was restrained in March 2014 after throwing ice and snow at staff persons. In that incident, the patient was warned that s/he “would need to be put in a restraint chair if s/he continued the behavior,” and there was no documentation that the behavior continued.¹¹⁰ Staff asserted that the patient had asked to be put in the restraint chair, although the patient told licensors s/he had stated that s/he did not need a restraint chair and had walked to the seclusion room.

DHS licensing then reviewed a total of 22 episodes of restraint and seclusion of this vulnerable adult (VA) during February 2014. Seventeen were sequential, such as manual restraint to seclusion to manual to restraint chair, so the actual total number was 55 uses of restraint and seclusion. Release criteria were iterations of “calm and controlled [or cooperative] behavior,” or “verbalize safety of self or others.”¹¹¹

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=LLO_25333.

¹⁰⁷ *Id.* at 21.

¹⁰⁸ *Id.* at 20.

¹⁰⁹ DIV. OF LICENSING, MINN. DEP’T HUM. SERVICES, VIOLATION AND CORRECTION ORDER (Oct. 28, 2014), *available at*

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=LLO_34987 (based on DIV. OF LICENSING, MINN. DEP’T HUM. SERVICES, INVESTIGATIVE MEMORANDUM #20141080 8 (Oct. 28, 2014), *available at*

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=LLO_35014).

¹¹⁰ *Id.* at 8.

¹¹¹ *Id.* at 5.

The licensing review found that in 22 of 22 required debriefing reviews by staff, the question “What could have been done differently by staff or [the VA]?” did not include any ideas of what the staff could have done differently. Sixteen of the reviews focused only on the VA and included “the VA should have used coping skills” or “the VA should not have engaged in self-injurious behavior” and “the VA was given many opportunities.” Six debriefing sessions did not include the VA because the team deemed it “un-therapeutic” or “counter-therapeutic” to include the VA in debriefing. Twelve sessions did not document why the VA was not included. Of particular note, in reviewing recommendations for changes to the treatment plan, eight times the recommendation was to initiate ECT on the VA. Other treatment plan recommendations included “PRN”, “more concrete rules and boundaries” and “the VA should use coping skills”.¹¹²

The Behavior Management Review Committee looked at this patient’s situation and suggested gathering more information on the VA’s aggressive behaviors, add an intervention to “just listen” and review use of the chair to see if it was being used as a “general plan of intervention.” There was no documentation that any of these recommended actions occurred. The Clinical Consultation Committee also reviewed this patient’s situation, to determine if any treatment plan changes were necessary. The committee discussed medication changes, ECT, and dialectical behavioral therapy. “Given the VA’s history of seeking “negative attention” including restraint and seclusion, the committee stated that it was important that the team document “imminent risk status” when using restraint and seclusion.¹¹³ The licensing review did not indicate what if any of these recommendations were implemented, but the hospital did obtain a court order for involuntary ECT.

g. OSHA Abatement Plan

In early 2014, staff members at MSH filed a complaint with the Occupational Safety and Health Administration (OSHA) regarding unsafe work conditions at MSH. OSHA opened an inspection on February 18, 2014 which ran until August 1, 2014. On August 4, 2014, OSHA issued a serious violation against DHS because “employees were not properly protected from workplace violence by an effective workplace violence prevention program.” On August 25, 2014, Commissioner Jesson filed a formal “Notice of Contest” to the violation.

Following the Notice of Contest, DHS management and staff entered into mediation conducted by the State of Minnesota Office of Administrative Hearings. At a legislative hearing on December 5, 2014, Anne Berry presented an “Abatement Plan” that was produced during the mediation sessions. The Abatement plan outlines eighteen action areas where DHS has taken or will take steps to create a safe work environment. Those action areas include:

- Redefine “imminent risk” to create a clearly written policy and provide staff with real-world scenario based training on imminent risk;
- Restructuring and empowering a “Safety Committee” to provide direct accountability to the Executive Director, inform policy development and implement safe conduct expectations for patients.

¹¹² *Id.* at 6.

¹¹³ *Id.* at 7.

- Conduct “violence assessments” on patients, improve technical safety skills of staff, abate blind spots on units, improved data driven decisions, and support for employees with career ending injuries.¹¹⁴
- h. Recommendations of the advocacy community, including MMLA/MDLC and publicly provided at a 5/22/14 press conference:**
- **Assign an outside person to monitor implementation** of the terms for the conditional license. It has simply not worked to have the department monitor itself. Monthly reports should be made to the commissioner, the governor and an oversight committee comprised of advocates and mental health professionals.
 - **Have all staff trained** in de-escalation techniques, appropriate use of seclusion and restraints, alternative to seclusion and restraints, relationship building, person driven planning and trauma informed care **within 60 days**. This goes beyond the 45 day requirement for management and supervisors and involves all line staff.
 - **Hire peer specialists for every unit**. Ensure that peer specialists are involved in all aspects of care and work side-by-side with staff as equals. They should be seen as professionals, providing feedback to staff. Their input should be sought out.
 - **Form an outside committee of community experts** to review and comment on the current training being provided at MSH to ensure that best practices are being used. Peer specialists should be included on this committee, along with advocates. We do not believe that the two-day person centered training and MANDT training is enough, especially for line staff working on the units where people are in crisis or have more serious symptoms.
 - **Engage community experts to be on site for the next 90 days** to monitor, guide and support a change in staff attitudes and the treatment of people with serious mental illnesses, especially as it relates to alternatives to the use of restraint and seclusion. The “mentor” required in the monitoring report should be from an outside agency, not an SOS employee. The experts should be used to review the data on the use of seclusion and restraints and injury data and should be involved in any debriefing meetings in order to inform future policies and procedures. They should be used to ensure consistent communication, mentoring, supervision and follow-up.
 - **Use assessment tools** to identify risk for violence restraint and seclusion history, trauma history and persons with high-risk factors for death and injury.
 - **Include the individual and his/her family** in developing the individual’s plan in order to identify triggers and strategies that have been helpful in the past.
 - **Increase the therapeutic programming** at the facility to at least 2 hours a day with a plan to reach at least 4 hours a day.
 - **Utilize outside consultants for the remodeling** of St Peter to include comfort and sensory rooms and other aspects that promote a therapeutic environment.
 - **MDLC also recommended** at the press conference the importance of bringing in outside consultants to evaluate treatment plans of individual patients, who have a

¹¹⁴ OAH ABATEMENT PLAN, *supra* note 34, at 1–2.

complex of issues including TBI, FAS, IDD, antisocial/criminal behavior, etc. which result in behavior and safety problems for them and other patients.

APPENDIX D

Unit 800 Fall Quarter 2014
 (September 29th to December 19th, 2014)

Key:

7:00	Wake up/Small Eat/Meds							
8:00	Breakfast							
9:00	Orientation Group C. Letson	Team Mtgs/ Quarterly Reviews		New Outlook Group C. Letson	Mental Health Ed Group Dr. Bollig		Doctor's Rounds	
9:45	Canteen	Canteen		Canteen	Canteen		Canteen	Canteen
10:15	Library Security Counselors	Qty Revs	Lib SC's	Library Security Counselors	DBT Gr Dr. Bollig	Lib SC's	Library Security Counselors	
11:15	ATS Security Counselors	ATS Security Counselors		ATS Security Counselors	ATS Security Counselors		ATS Security Counselors	
12:00	12:00 Lunch							
12:30	Stress Management R. Winter	Anger Management R. Winter		Community Meeting Security Counselors	Gardening/ Coping Skills S. Cowan			
12:45				Foundations R. Winter				
1:15	Creative Expression S. Cowan			Relaxation Group (1:30) S. Cowan				
2:00	2:00 Lunch							
2:15	Movie Group C. Letson	Gardening/ Coping Skills S. Cowan					IMR Group Unit 800 Nsg	
3:00								
3:15	Canteen	Canteen		Canteen	Canteen		Canteen	Canteen
5:00	5:00 Dinner							
5:30	Building wide activities							
7:15	Canteen	Canteen		Canteen	Canteen		Canteen	Canteen
7:30	Medications and evening snack time							

*This schedule reflects all scheduled groups and activities weekly. This schedule does not include: Individual Sessions or unplanned evening and weekend activities.



Minnesota Department of **Human Services**

October 30, 2013

By Overnight Mail and E-mail as requested

David Ferleger, Esq.
Independent Consultant and *Jensen* Court Monitor
Archways Professional Building
413 Johnson Street, Suite 203
Jenkintown, PA 19046

Re: *James and Lori Jensen, et al. v. Minnesota Department of Human Services, et al.*
Court File No.: 09-CV-01775 DWF/FLN

Dear Mr. Ferleger:

This is with regard to your request titled, "Request No. 2013-10: AMRTC and MSH Records on Restraint Chair and Seclusion Use" dated October 18, 2013 (attached). The request also pertains to "Rationale for Document Request: Restraint Chair and Seclusion Use at AMRTC and MSH: Phase 1 Review" which was filed with the Court on October 17, 2013. The due date for the requested materials is 15 days from the date of the October 18, 2013 request which is Saturday November 2, 2013.

Enclosed, please find two copies of the documentation requested relating to items one to six as listed in your request for the four sampled individuals.

Thank-you for the extension to November 18, 2013 for the following item which will be sent to you directly digitally/electronically as requested on or before November 18, 2013:

7. Within 15 days of this request. DHS will digitally provide the Court Monitor any analyses, DHS internal or public reports, consultant reports, or the like, regarding Restraint Chair, Seclusion or restraint use within State Operated Services, which analyze or discuss the magnitude or reasons for restraint/seclusion use and/or means or proposals for changes in policy or practice. The time period for this Par. 7 request is January 1, 2008 to the present.

As requested, I will also be sending the following electronically by email to you on or before November 2, 2013:

8. Within 15 days of this request. DHS will digitally provide the Court Monitor with all AMRTC and MSR policies and forms regarding use of restraints or seclusion which are in effect as of October 18, 2013 or were in effect since January 1, 2008 (indicating as to each the effective dates).

Please note that some of the historical materials requested in items 7 and 8 back to 2008, may not be available due to record retention requirements.

Please let me know if there is anything you need further.

Sincerely,

A handwritten signature in black ink that reads "Christina Baltes". The signature is written in a cursive style and is positioned above a horizontal line.

Christina Baltes, RN, BSN, PHN, MA, QDDP/QIDP
Jensen Compliance Officer

Mailed Cc w/o enclosures: The Honorable Donovan W. Frank
E-mail CC w/o enclosures: Shamus O'Meara, Attorney for Plaintiffs
Colleen Wieck, Executive Director for the Governor's Council on
Developmental Disabilities
Roberta Opheim, Ombudsman for Mental Health and Developmental
Disabilities
Steven Alpert, Assistant Attorney General
Scott Ikeda, Assistant Attorney General
Gregory Gray, DHS Chief Compliance Officer
Amy Kaldor Akbay, DHS Chief General Counsel